99TH CONGRESS
1ST SESSION

H. R. 3290

To amend titles XVIII and XIX to provide for budget reconciliation with respect to the health care programs under the Social Security Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 12, 1985

Mr. ROSTENKOWSKI (for himself, Mr. DINGELL, Mr. STARK, and Mr. WAXMAN) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend titles XVIII and XIX to provide for budget reconciliation with respect to the health care programs under the Social Security Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—HEALTH CARE PROGRAMS

SEC. 100. SHORT TITLE; TABLE OF CONTENTS OF TITLE.

This title may be cited as the "Medicare and Medicaid Budget Reconciliation Amendments of 1985".

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PART A—CHANGES RELATING PRIMARILY TO PART A OF THE MEDICARE PROGRAM

Subpart 1—Hospital Payment Rates

SEC. 101. RATE OF INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.

(a) SETTING APPLICABLE PERCENTAGE AT ONE PERCENT.—The second sentence of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended to read as follows: "Notwithstanding the previous sentence or subsection (e), for purposes of subparagraph (A) for cost reporting periods beginning during fiscal year 1986 and for purposes of subsection (d)(3)(A) for discharges occurring during that fiscal year, the applicable percentage increase shall be one percent.".

(b) APPLICATION TO DRG PAYMENT SYSTEM.—Section 1886(d)(3)(A) of such Act is amended by striking out "for fiscal year 1985" and inserting in lieu thereof "for each of fiscal years 1985 and 1986".

(c) NO SECRETARIAL DISCRETION FOR FISCAL YEAR 1986.—Section 1886(e)(4) of such Act is amended by striking out "1986" and inserting in lieu thereof "1987".

SEC. 102. ONE-YEAR EXTENSION OF DRG TRANSITION.

(a) MAINTAINING CURRENT BLEND FOR ONE YEAR.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended by striking out "1985" and

"1986" and inserting in lieu thereof "1986" and "1987", respectively, each place either appears.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods, and discharges in fiscal years, beginning on or after October 1, 1985.

SEC. 103. APPLICATION OF REVISED HOSPITAL WAGE INDEX.

(a) APPLICATION OF REVISED INDEX PROSPECTIVELY.—(1) Subsection (b) of section 2316 of the Deficit Reduction Act of 1984 (Public Law 98–369; 98 Stat. 1081) is amended to read as follows:

"(b) The Secretary shall adjust the payment amounts for hospitals for discharges occurring during fiscal year 1986 to reflect the changes the Secretary has proposed (in the Federal Register on June 10, 1985) in regulations respecting the hospital wage index under section 1886(d)(3)(E) of the Social Security Act, as that proposal relates to the use of total gross hospital wages. For discharges occurring after September 30, 1986, the Secretary shall provide for such periodic adjustments in the appropriate wage index used under that section as may be necessary, taking into account changes in the wage differences of full-time and part-time workers.".

(2) The amendment made by paragraph (1) shall be effective as if it had been included in the Deficit Reduction Act of 1984.

(b) STUDY OF METHODOLOGY FOR AREA WAGE ADJUSTMENT FOR CENTRAL CITIES.—(1) The Secretary of Health and Human Services, in consultation with the Prospective Payment Assessment Commission, shall collect information and shall develop one or more methodologies to permit the adjustment of the wage indices used for purposes of sections 1886(d)(2)(C)(ii), 1886(d)(2)(H), and 1886(d)(3)(E) of the Social Security Act, in order to more accurately reflect hospital labor markets, by taking into account variations in wages and wage-related costs between the central city portion of urban areas and other parts of urban areas.

(2) The Secretary shall report to Congress on the information collected and the methodologies developed under paragraph (1) not later than May 1, 1986. The report shall include a recommendation as to the feasibility and desirability of implementing such methodologies.

SEC. 104. CHANGE IN FORMULA FOR INDIRECT TEACHING ADJUSTMENT.

(a) SUBSTITUTION OF NEW FORMULA.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(1) by inserting "(i)" after "(B)",

(2) in the first sentence—

(A) by inserting "for discharges occurring during fiscal years 1984 and 1985" after "except that", and

(B) by inserting before the period at the end the following: ", and except that for discharges for fiscal years after fiscal year 1985 the payment amount shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii)", and

(3) by adding at the end the following new clause:

"(ii) For purposes clause (i)(II), the indirect teaching adjustment factor for discharges occurring—

"(I) during fiscal years 1986 and 1987, is equal to 2 x $[(1+r)^{\circ} -1]$, where 'r' is the ratio of the hospital's full-time equivalent interns and residents (including those assigned to outpatient departments of the hospital) to beds and '°' is .405, or

"(II) after fiscal year 1987, is equal to 1.5 x $[(1+r)^{\circ} -1]$, where 'r' is the same as 'r' under subclause (I) and '°' is .5795.".

(b) ADJUSTMENT OF PAYMENT AMOUNTS.—

(1) RESTANDARDIZING DRG PAYMENT AMOUNTS TO REFLECT CHANGE IN FORMULA.—Section 1886(d)(2)(C)(i) of such Act is amended by inserting "(taking into account, for discharges occurring after September 30, 1985, the amendments made by section 104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)" after "medical education costs".

(2) PROVIDING FOR SYSTEM SAVINGS FROM CHANGE IN FORMULA.—Subparagraph (C) of section 1886(d)(3) of such Act is amended—

(A) by inserting "(i)" after "(C)",

(B) by inserting "FOR FISCAL YEAR 1985" after "NEUTRALITY",

(C) by striking out "The Secretary" and inserting in lieu thereof "For discharges occurring in fiscal year 1985, the Secretary", and

(D) by adding at the end the following new clause:

"(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR SUBSEQUENT FISCAL YEARS.—For discharges occurring after fiscal year 1985, the Secretary shall further reduce each of the average standardized amounts (in a

proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring during—

"(i) each of fiscal years 1986 and 1987, of an amount equal to the estimated reduction in the additional payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 if the factor described in clause (ii)(II) of paragraph (5)(B) were applied for each respective fiscal year instead of the factor described in clause (ii)(I) of that paragraph, and

"(ii) each fiscal year thereafter, of an amount equal to the estimated reduction in the additional payment amounts under paragraph (5)(B) for that fiscal year that has resulted from the enactment of the amendments made by section 104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985.".

(3) CONFORMING AMENDMENT.—Clauses (i)(I) and (ii)(I) of section 1886(d)(3)(D) of such Act are each

amended by inserting "or reduced" after "(B), and adjusted".

SEC. 105. COMPUTATION OF ADDITIONAL PAYMENT AMOUNTS FOR HOSPITALS SERVING A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS.

(a) REQUIRING ADJUSTMENT.—Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended by adding at the end the following new subparagraph:

"(F)(i) The Secretary shall provide under this subparagraph, for discharges occurring during fiscal years 1986 and 1987, for an additional payment amount, for discharges occurring in a cost reporting period of a hospital, for a subsection (d) hospital that is located in an urban area, that has 100 or more beds, and that—

"(I) serves a significantly disproportionate number of patients who have low income (as defined in clause (iv)(I)), or

"(II) can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this title or State plans approved under title XIX) during the cost reporting period for indigent care from State and local government sources exceed 30 percent of its total of such revenues during the period.

"(ii) The amount of such payment for each discharge shall be the amount determined under paragraph (1)(A)(ii)(II)

(or, if applicable, the amount determined under paragraph (1)(A)(iii)) for that discharge multiplied by the disproportionate share adjustment percentage established under clause (iii) for the cost reporting period in which the discharge occurs.

"(iii) The disproportionate share adjustment percentage for a cost reporting period—

"(I) for a hospital described in clause (i)(II) is equal to 16 percent, and

"(II) for other hospitals is equal to seven-tenths of the excess low income patient percentage (as defined in clause (iv)(IV)) for that period,

but in no case may the percentage for any hospital for any period exceed 16 percent.

"(iv) In this subparagraph:

"(I) A hospital 'serves a significantly disproportionate number of patients who have low income' for a cost reporting period if the hospital has a low income patient percentage (as defined in subclause (II)) for that period which equals, or exceeds, 15 percent.

"(II) The term 'low income patient percentage' means, with respect to a cost reporting period of a hospital, the percentage of its total number of patient days of inpatient hospital services it provided during period which are attributable to low income patients (as defined in subclause (III)).

"(III) The term 'low income patient' means, with respect to inpatient hospital services provided to a patient, a patient who was, or is determined to have been, entitled to medical assistance under title XIX with respect to some or all of such services during the hospital stay, and includes such an individual notwithstanding the fact that some or all of such services were actually paid for under this title.

"(IV) The term 'excess low income patient percentage' means, for a cost reporting of a hospital, the hospital's low income patient percentage (as defined in subclause (II)) for that period minus 15 percent.".

(b) RESTANDARDIZING DRG PAYMENT AMOUNTS TO REFLECT DISPROPORTIONATE SHARE PAYMENTS.—Section 1886(d)(2)(C) of such Act is amended—

(1) by striking out "and" at the end of clause (ii),

(2) by striking out the period at the end of clause (iii) and inserting in lieu thereof ", and", and

(3) by adding at the end the following new clause:

"(iv) for discharges occurring during fiscal years 1986 and 1987, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F).".

SEC. 106. TREATMENT OF CERTAIN RURAL OSTEOPATHIC HOSPITALS AS RURAL REFERRAL CENTERS.

(a) IN GENERAL.—Section 1886(d)(5)(C)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(C)(i)) is amended by inserting before the period at the end of the second sentence the following: "and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

SEC. 107. ONE-YEAR PROHIBITION ON FREEZING COST INCREASES THAT MAY BE RECOGNIZED FOR DIRECT MEDICAL EDUCATION.

(a) RULE.—The Secretary of Health and Human Services may not implement any regulation that would limit, under the authority of section 1861(v) of the Social Security Act, the costs that may be recognized as reasonable under title XVIII of that Act with respect to the net costs of approved educational activities for a cost reporting period based upon the net costs of those activities for any previous cost reporting period.

(b) EFFECTIVE PERIOD.—The prohibition of subsection (a) shall apply to the cost reporting periods beginning during the one-year period beginning on July 1, 1985.

SEC. 108. RETURN ON EQUITY CAPITAL FOR INPATIENT HOSPITAL SERVICES AND OTHER SERVICES.

(a) INPATIENT HOSPITAL SERVICES.—(1) Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(P) Such regulations may not provide for any payment, with respect to the reasonable costs of inpatient hospital services, for a return on equity capital for hospitals.".

(2) Section 1886(g) of such Act (42 U.S.C. 1395ww(g)) is amended—

(A) by striking out "(1)" after "(g)", and

(B) by striking out paragraph (2).

(b) OTHER SERVICES.—(1) Section 1861(v)(1)(P) of such Act, as added by subsection (a)(1), is amended by inserting "(i)" after "(P)" and by adding at the end the following new clause:

"(ii) If such regulations provide for the payment for a return on equity capital, the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.".

(2) Section 1861(v)(1)(B) of such Act (42 U.S.C. 1395x(v)(1)(B)) is amended—

(A) by striking out "any fiscal period" and "such fiscal period" and inserting in lieu thereof "any cost reporting period" and "the period", respectively, and

(B) by striking out "not exceed one and one-half times" in the second sentence and inserting in lieu thereof "be equal to".

(c) EFFECTIVE DATES.—(1) The amendments made by subsection (a) shall apply to payments made, on the basis of reasonable cost, for hospital cost reporting periods beginning on or after October 1, 1986. Costs attributable to a return on equity capital shall not be included in determining national and regional adjusted DRG prospective payment rates (under section 1886(d) of the Social Security Act) for discharges occurring on or after October 1, 1986.

(2) The amendments made by subsection (b) shall apply to cost reporting periods beginning on or after October 1, 1985.

SEC. 109. CONTINUATION OF MEDICARE REIMBURSEMENT WAIVERS FOR CERTAIN HOSPITALS SUBJECT TO REGIONAL HOSPITAL REIMBURSEMENT DEMONSTRATIONS.

For purposes of section 1886(c) of the Social Security Act (including paragraph (4) thereof), a hospital reimbursement control system which, on January 1, 1985, was carrying out a demonstration under a contract which had been

approved by the Secretary of Health and Human Services under section 222(a) of the Social Security Amendments of 1972 shall be deemed (as of the date of the enactment of this Act) to meet the requirements of section 1886(c)(1)(A) of the Social Security Act if the system applies—

(1) to substantially all non-Federal acute care hospitals (as defined by the Secretary for purposes of that section) in the geographic area served by the system on January 1, 1985; and

(2) to the review of at least 75 percent—

(A) of all revenues or expenses in such geographic area for inpatient hospital services, and

(B) of revenues or expenses in the geographic area for inpatient hospital services provided under the applicable State plan approved under title XIX of the Social Security Act.

SEC. 110. FOUR-YEAR TEST FOR STATE WAIVERS FOR CERTAIN STATES.

(a) IN GENERAL.—Section 1886(c) of the Social Security Act (42 U.S.C 1395ww(c)) is amended by adding at the end the following new paragraph:

"(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

"(A) in applying paragraphs (1)(C) and (6), a reference to a '36-month period' is deemed a reference to as '48-month period', and

"(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 111. SPECIAL RULE FOR TREATMENT OF DEPRECIATION AND CAPITAL INDEBTEDNESS FOR DONATIONS OF STATE PROPERTY TO NON-PROFIT CORPORATIONS.

(a) GENERAL RULE.—Section 1861(v)(1)(O) of the Social Security Act (42 U.S.C. 1395x(v)(1)(O)) is amended—

(1) by inserting ", except as provided in clause (iv)," in clause (i) after "such regulations shall provide", and

(2) by adding at the end the following new clause:

"(iv) In the case of the transfer of a hospital or skilled nursing facility from ownership by a State to ownership by a

non-profit corporation without monetary consideration, clause (i) shall be applied without regard to the acquisition cost of the hospital or facility to the new owner.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be applied as though they were included in the Deficit Reduction Act of 1984.

SEC. 112. REPORT ON IMPACT OF OUTLIER AND TRANSFER POLICY ON RURAL HOSPITALS.

(a) REVIEW.—The Secretary of Health and Human Services shall review the impact of policies respecting outliers and patient transfers on payments under section 1886(d) of the Social Security Act to rural hospitals (particularly on rural hospitals with less than 100 beds).

(b) REPORT.—The Secretary shall report to Congress on the findings of the review not later than May 1, 1986, and shall include in the report recommendations on changes in policies respecting outliers and patient transfers to the extent they adversely affect rural hospitals.

SEC. 113. INFORMATION ON IMPACT OF PPS PAYMENTS ON HOSPITALS.

(a) DISCLOSURE OF INFORMATION.—The Secretary of Health and Human Services shall make available to the Prospective Payment Assessment Commission, the Congressional Budget Office, and to the Committee on Ways and Means of the House of Representatives and the Committee on Fi-

nance of the Senate the most current information on the payments being made under section 1886 of the Social Security Act to individual hospitals. Such information shall be made available in a manner that permits examination of the impact of such section on hospitals.

(b) CONFIDENTIALITY.—Information disclosed under subsection (a) shall be treated as confidential and shall not be subject to further disclosure in a manner that permits the identification of individual hospitals.

Subpart 2—Benefits, Coverage, Premiums, and Provider Agreements

SEC. 121. EXTENSION AND PAYMENT FOR HOSPICE CARE.

(a) ELIMINATION OF SUNSET.—Section 122(h)(1) of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, 96 Stat. 362), relating to the end of the effective date for hospice care, is amended—

(1) in subparagraph (A)—

(A) by striking out "(h)(1)(A) Subject to subparagraph (B), the" and inserting in lieu thereof "(h)(1) The", and

(B) by striking out ", and before October 1, 1986", and

(2) by striking out subparagraph (B).

(b) INCREASE IN PAYMENT OF DAILY RATES FOR HOSPICE CARE FOR FISCAL YEAR 1986.—(1) Subpara-

graph (B) of section 1814(i)(1) of the Social Security Act (42 U.S.C. 1395f(i)(1)) is amended to read as follows:

"(B) Notwithstanding subparagraph (A) and for hospice care furnished on or after October 1, 1985, the daily rate of payment per day for routine home care shall be $63.17 and the daily rate of payment for other services included in hospice care shall be the daily rate of payment recognized under subparagraph (A) as of July 1, 1985, increased by $10.".

(2) Subparagraph (C) of such section is amended by striking out "1985" and inserting in lieu thereof "1986".

SEC. 122. LIMITING THE PENALTY FOR LATE ENROLLMENT IN PART A.

(a) LIMITING PENALTY TO 10 PERCENT AND TWICE THE PERIOD DURING WHICH NOT ENROLLED.—Section 1818(c) of the Social Security Act (42 U.S.C. 1395i-2(c)) is amended—

(1) by striking out "and" at the end of paragraph (5),

(2) by striking out the period at the end of paragraph (6) and inserting in lieu thereof "; and", and

(3) by adding at the end the following new paragraph:

"(7) any percent increase effected under section 1839(b) in an individual's monthly premium may not exceed 10 percent and shall only apply to premiums

paid during a period equal to twice the number of months in the full 12-month periods described in that section.''.

(b) EFFECTIVE DATE.—(1) The amendment made by subsection (a)(3) shall apply to premiums paid for months beginning with January 1986.

(2) In applying that amendment, months (before, during, or after January 1986) in which an individual was required to pay a premium increased under the section that was so amended shall be taken into account in determining the month in which the premium will no longer be subject to an increase under that section as so amended.

SEC. 123. MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, NEWLY HIRED STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) APPLICATION OF HOSPITAL INSURANCE TAX TO NEWLY HIRED EMPLOYEES OF STATE AND LOCAL GOVERNMENTS.—

(1) IN GENERAL.—Subsection (u) of section 3121 of the Internal Revenue Code of 1954 (relating to application of hospital insurance tax to Federal employment) is amended to read as follows:

''(u) APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL, STATE, AND LOCAL EMPLOYMENT.—

"(1) FEDERAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b), subsection (b) shall be applied without regard to paragraph (5) thereof.

"(2) STATE AND LOCAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b)—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), subsection (b) shall be applied without regard to paragraph (7) thereof.

"(B) EXCEPTION FOR CERTAIN SERVICES.—Service shall not be treated as employment by reason of subparagraph (A) if—

"(i) the service is included under an agreement under section 218 of the Social Security Act, or

"(ii) the service is performed—

"(I) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

"(II) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political

subdivision thereof or of the District of Columbia,

"(III) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, or

"(IV) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training.

As used in this subparagraph, the terms 'State' and 'political subdivision' have the meanings given those terms in section 218(b) of the Social Security Act.

"(C) EXCEPTION FOR CURRENT EMPLOYMENT WHICH CONTINUES.—Service performed for an employer shall not be treated as employment by reason of subparagraph (A) if—

"(i) such service would be excluded from the term 'employment' for purposes of this chapter if subparagraph (A) did not apply;

"(ii) such service is performed by an individual—

"(I) who was performing substantial and regular service for remuneration for that employer before January 1, 1986,

"(II) who is a bona fide employee of that employer on December 31, 1985, and

"(III) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

"(iii) the employment relationship with that employer has not been terminated after December 31, 1985.

"(D) TREATMENT OF AGENCIES AND INSTRUMENTALITIES.—For purposes of subparagraph (C), under regulations—

"(i) All agencies and instrumentalities of a State (as defined in section 218(b) of the

Social Security Act) or of the District of Columbia shall be treated as a single employer.

"(ii) All agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in clause (i).

"(3) MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT.—For purposes of this chapter, the term 'medicare qualified government employment' means service which—

"(A) is employment (as defined in subsection (b)) with the application of paragraphs (1) and (2), but

"(B) would not be employment (as so defined) without the application of such paragraphs."

(2) CONFORMING AMENDMENTS.—

(A)(i) Section 3125 of such Code (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) is amended by redesignating subsections (a), (b), and (c) as subsections (b), (c), and (d), respectively, and by inserting before subsection (b) (as so redesignated) the following new subsection:

"(a) STATES.—Except as otherwise provided in this section, in the case of the taxes imposed by sections 3101(b) and 3111(b) with respect to service performed in the employ of a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby), the return and payment of such taxes may be made by the head of the agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1)."

(ii) The section heading for such section 3125 is amended by inserting "**STATES,**" before "**GUAM**".

(iii) The item relating to section 3125 in the table of sections for subchapter C of chapter 21 of such Code is amended by inserting "States," before "Guam".

(B) Subsection (b) of section 1402 of such Code is amended by striking out "medicare qualified Federal employment (as defined in section 3121(u)(2))" and inserting in lieu thereof "medi-

care qualified government employment (as defined in section 3121(u)(3))".

(C) Section 3122 of such Code (relating to Federal service) is amended by striking out "including service which is medicare qualified Federal employment (as defined in section 3121(u)(2))" and inserting in lieu thereof "including such service which is medicare qualified government employment (as defined in section 3121(u)(3))".

(D) Subsection (a) of 6205 of such Code (relating to special rules applicable to certain employment taxes) is amended by adding at the end thereof the following new paragraph:

"(5) STATES AND POLITICAL SUBDIVISIONS AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality, and each agent designated by either, who makes a return pursuant to section 3125 shall be deemed a separate employer."

(E)(i) Section 6413(a) of such Code (relating to adjustment of certain employment taxes) is

amended by adding at the end thereof the following new paragraph:

"(5) STATES AND POLITICAL SUBDIVISIONS AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality, and each agent designated by either, who makes a return pursuant to section 3125 shall be deemed a separate employer."

(ii) Section 6413(c)(2) of such Code (relating to special refunds of certain employment taxes) is amended—

(I) by striking out "3125(a)", "3125(b)", and "3125(c)" in subparagraphs (D), (E), and (F), respectively, and inserting in lieu thereof "3125(b)", "3125(c)", and "3125(d)", respectively, and

(II) by adding at the end thereof the following new subparagraph:

"(G) EMPLOYEES OF STATES AND POLITICAL SUBDIVISIONS.—In the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more

of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality, and each agent designated by either, who makes a return pursuant to section 3125(a) shall, for purposes of this subsection, be deemed a separate employer."

(b) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—

(1) REVISION OF DEFINITION OF MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT.—Section 210(p) of the Social Security Act (42 U.S.C. 410(p)) is amended to read as follows:

"Medicare Qualified Government Employment

"(p)(1) For purposes of sections 226 and 226A, the term 'medicare qualified government employment' means any service which would constitute 'employment' as defined in subsection (a) of this section but for the application of the provisions of—

"(A) subsection (a)(5), or

"(B) subsection (a)(7), except as provided in paragraphs (2) and (3).

"(2) Service shall not be treated as employment by reason of paragraph (1)(B) if the service is performed—

"(A) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

"(B) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

"(C) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, or

"(D) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training.

As used in this paragraph, the terms 'State' and 'political subdivision' have the meanings given those terms in section 218(b).

"(3) Service performed for an employer shall not be treated as employment by reason of paragraph (1)(B) if—

"(A) such service would be excluded from the term 'employment' for purposes of this section if paragraph (1)(B) did not apply;

"(B) such service is performed by an individual—

"(i) who was performing substantial and regular service for remuneration for that employer before January 1, 1986,

"(ii) who is a bona fide employee of that employer on December 31, 1985, and

"(iii) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

"(C) the employment relationship with that employer has not been terminated after December 31, 1985.

"(4) For purposes of paragraph (3), under regulations (consistent with regulations established under section 3121(u)(2)(D) of the Internal Revenue Code of 1954)—

"(A) all agencies and instrumentalities of a State (as defined in section 218(b)) or of the District of Columbia shall be treated as a single employer, and

"(B) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treat-

ed as a single employer and shall not be treated as described in subparagraph (A).".

(2) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—

(A) FOR INDIVIDUALS AGE 65 OR OLDER AND FOR DISABLED INDIVIDUALS.—Section 226 of such Act (42 U.S.C. 426) is amended by striking out "medicare qualified Federal employment" in subsections (a)(2)(C)(i) and (b)(2)(C)(ii)(I) and inserting in lieu thereof "medicare qualified government employment".

(B) FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.—Section 226A(a) of such Act (42 U.S.C. 426-1(a)) is amended by striking out "medicare qualified Federal employment" in paragraphs (1)(A)(ii) and (1)(B)(iii) and inserting in lieu thereof "medicare qualified government employment".

(C) CONFORMING AMENDMENTS.—

(i) Section 1811 of such Act (42 U.S.C. 1395c) is amended by striking out "Federal employment" in clauses (1) and (2) and inserting in lieu thereof "government employment".

(ii) Section 226(g) of such Act (42 U.S.C. 426(g)) is amended by striking out "medicare qualified Federal employment" and inserting in lieu thereof "medicare qualified government employment by virtue of service described in section 210(a)(5)".

(c) EFFECTIVE DATES.—

(1) HOSPITAL INSURANCE TAXES.—The amendments made by subsection (a) shall apply to services performed after December 31, 1985.

(2) MEDICARE COVERAGE.—

(A) IN GENERAL.—The amendments made by subsection (b) shall be effective after December 31, 1985, and the amendments made by paragraph (3) of that subsection shall apply to services performed (for medicare qualified government employment) after that date.

(B) TREATMENT OF CERTAIN DISABILITIES.—For purposes of establishing entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act pursuant to the amendments made by subsection (b), no individual may be considered to be under a disability for any period beginning before January 1, 1986.

SEC. 124. RESPONSIBILITIES OF MEDICARE HOSPITALS IN EMERGENCY CASES.

(a) REQUIREMENT OF MEDICARE HOSPITAL PROVIDER AGREEMENTS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking out "and" at the end of subparagraph (G),

(2) by striking out the period at the end of subparagraph (H) and inserting in lieu thereof ", and", and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable.".

(b) REQUIREMENTS.—Title XVIII of such Act is amended by inserting after section 1866 the following new section:

"EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR

"SEC. 1867. (a) MEDICAL SCREENING REQUIREMENT.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital

must provide for an appropriate medical screening examination to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

"(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

"(1) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, unless the examination or treatment is refused, or

"(2) for transfer of the patient to another medical facility in accordance with subsection (c).

"(c) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZED.—

"(1) RULE.—If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

"(A) a physician (within the meaning of section 1861(r)(1)) has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer, and

"(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

"(2) APPROPRIATE TRANSFER.—An appropriate transfer to a medical facility is a transfer—

"(A) in which the receiving facility—

"(i) has available space and qualified personnel for the treatment of the patient, and

"(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment, and

"(iii) is being provided appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring facility;

"(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

"(C) in which the transfer is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures during the transfer; and

"(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

"(d) ENFORCEMENT.—

"(1) AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.—Failure of a hospital to meet the requirements of this section subjects the hospital to termination of its medicare provider agreement under this title, in accordance with section 1866(b).

"(2) CIVIL MONETARY PENALTIES.—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation. As used in the previ-

ous sentence, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

"(A) is employed by, or under contract with, the participating hospital, and

"(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

"(3) CIVIL ENFORCEMENT.—Any individual who suffers personal harm and any medical facility which suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain damages and other appropriate relief. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

"(e) DEFINITIONS.—In this section:

"(1) The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.

"(2) The term 'active labor' means labor at a time at which—

"(A) delivery is imminent,

"(B) there is inadequate time to effect safe transfer to another hospital, or

"(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

"(3) The term 'participating hospital' means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

"(4)(A) The term 'to stabilize' means, with respect to a medical condition, to provide such medical treatment of the condition as may be necessary to assure that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

"(B) The term 'stabilized' means, with respect to a medical condition, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

"(5) The term 'transfer' means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

"(f) PREEMPTION.—The provisions of this section do not preempt any State or local law requirement respecting hospitals, except to the extent that the requirement directly conflicts with a requirement of this section.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 1985.

PART B—CHANGES RELATING TO PARTS A AND B OF THE MEDICARE PROGRAM

SEC. 131. EXTENSION OF WORKING AGED PROVISIONS TO INDIVIDUALS OVER 69.

(a) EXTENSION OF MEDICARE AS SECONDARY PAYOR.—Section 1862(b)(3)(A) of the Social Security Act (42 U.S.C. 1395y(b)(3)(A)) is amended—

(1) in clause (i), by striking out "who is under 70 years of age during any part of such month" and ", if the spouse is under 70 years of age during any part of such month", and

(2) in clause (iii), by striking out "and ending with the month before the month in which such individual attains the age of 70".

(b) EXTENSION OF ANTI-DISCRIMINATION PROVISIONS.—

(1) Section 4(g)(1) of the Age Discrimination in Employment Act of 1967 (29 U.S.C. 623(g)(1)) is amended by striking out "through 69" and inserting in lieu thereof "or older" each place it appears.

(2) Section 12(a) of such Act (29 U.S.C. 631(a)) is amended by inserting "(except the provisions of section 4(g))" after "Act".

(c) CONFORMING AMENDMENTS.—

(1) SPECIAL ENROLLMENT PERIOD.—Paragraph (3) of section 1837(i) of the Social Security Act (42 U.S.C. 1395p(i)(3)) is amended to read as follows:

"(3) The special enrollment period referred to in paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv)

by reason of current employment and ending seven months later.".

(2) EFFECTIVE DATE OF ENROLLMENT.—Subsection (e) of section 1838 of the Social Security Act (42 U.S.C. 1395q) is amended to read as follows:

"(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3)—

"(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of that month, or

"(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls."

(d) EFFECTIVE DATES.—(1) The amendments made by subsection (a) shall apply with respect to items and services furnished on or after January 1, 1986.

(2) The amendments made by subsection (b) shall become effective on January 1, 1986.

(3) The amendments made by subsection (c) shall take effect on January 1, 1986, but shall not apply to any individual with respect to whom a special enrollment period under section 1837(i)(3) began before that date.

SEC. 132. PROVISIONS RELATING TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) FINANCIAL RESPONSIBILITY FOR PATIENTS HOSPITALIZED ON THE EFFECTIVE DATE OF AN ENROLLMENT OR DISENROLLMENT.—(1) Subsection (c) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new paragraph:

"(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

"(A) enrollment with an eligible organization under this section—

"(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

"(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

"(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

"(B) termination of enrollment with an eligible organization under this section—

"(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

"(ii) payment for such services during the stay shall not be made under section 1886(d), and

"(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.".

(2) Subsection (a)(3) of such section is amended by striking out "Payments" and inserting in lieu thereof "Subject to subsection (c)(7), payments".

(3) Subsection (a)(6) of such section is amended by striking out "If" and inserting in lieu thereof "Subject to subsection (c)(7), if".

(b) DISENROLLMENTS.—

(1) EFFECTIVE DATE.—Subsection (c)(3)(B) of such section is amended by striking out "a full calendar month after" and inserting in lieu thereof "the date on which".

(2) INFORMATION.—Such subsection is further amended by adding at the end the following: "In the

case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.''.

(c) REVIEW OF MARKETING MATERIAL.—Subsection (c)(3)(C) of such section is amended by adding at the end the following: ''No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.''.

(d) PROMPT PUBLICATION OF AAPCC.—Subsection (a)(1)(A) of such section is amended by inserting after ''The Secretary shall annually determine'' the following: '', and

shall publish not later than September 7 before the calendar year concerned".

(e) EFFECTIVE DATES.—

(1) FINANCIAL RESPONSIBILITY.—The amendments made by subsection (a) shall apply to enrollments and disenrollments that become effective on or after October 1, 1985.

(2) DISENROLLMENTS.—The amendments made by subsection (b) shall apply to requests for termination of enrollment submitted on or after October 1, 1985.

(3) MATERIAL REVIEW.—(A) The amendment made by subsection (c) shall not apply to material which has been distributed before October 1, 1985.

(B) Such amendment also shall not apply so as to require the submission of material which is distributed before November 15, 1985.

(C) Such amendment shall also not apply to material which the Secretary determines has been prepared before the date of the enactment of this Act and for which a commitment for distribution has been made, if the application of such amendment would constitute a hardship for the organization involved.

(4) PUBLICATION.—The amendment made by subsection (d) shall apply to determinations of per capita rates of payment for 1987 and subsequent years.

(5) NECESSARY MODIFICATION OF CONTRACTS.—The Secretary of Health and Human Services shall provide for such changes in the risk-sharing contracts which have been entered into under section 1876 of the Social Security Act as may be necessary to conform to the requirements imposed by the amendments made by this section on a timely basis.

SEC. 133. EVALUATION OF PREADMISSION AND PRE-PROCEDURE CERTIFICATION PROGRAMS.

(a) EFFECTIVENESS OF 100 PERCENT REVIEW.—The Secretary of Health and Human Services shall evaluate the relative effectiveness of peer review organizations that require preadmission certification of 100 percent of elective inpatient surgical procedures with other peer review organizations that require such certification of a lesser percentage of such procedures.

(b) FEASIBILITY OF PRE-PROCEDURE CERTIFICATION FOR OUTPATIENT SURGICAL PROCEDURES.—The Secretary also shall evaluate the feasibility of extending the pre-procedure certification activities of peer review organizations to cover elective surgical procedures conducted in outpatient and ambulatory care settings. In doing the evaluation, the Secretary shall consider the extent to which entities with contracts with the Secretary under section 1842 of the Social Security Act and other entities might perform such activities

more efficiently and effectively than peer review organizations.

(c) REPORT.—The Secretary shall report to Congress, not later than December 31, 1986, on the results of the evaluations conducted under this section.

(d) DEFINITIONS.—In this section, the term "peer review organization" means a utilization and quality control peer review organization with a contract under part B of title XI of the Social Security Act.

SEC. 134. PROHIBITION OF ADMINISTRATIVE MERGER OF RENAL DISEASE NETWORKS WITH OTHER ORGANIZATIONS.

The Secretary of Health and Human Services may not provide for the merger of any renal disease network (established under section 1881(c) of the Social Security Act) into a utilization and quality control peer review organization (with a contract under part B of title IX of such Act) or another entity without express statutory authorization.

SEC. 135. EXTENSION OF CERTAIN MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

The Secretary of Health and Human Services shall extend, for a period of three additional years, approval of three municipal health services demonstration projects (locat-

ed in Cincinnati, Milwaukee, and San Jose) authorized under section 402(a) of the Social Security Amendments of 1967.

SEC. 136. TECHNICAL CORRECTIONS.

(a) WORKING AGED TECHNICAL CORRECTIONS.—

(1) PREMIUM PENALTY.—The second sentence of section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)), as amended by section 2338(a) of the Deficit Reduction Act of 1984, is amended by striking out "months in which" and all that follows through "clause (iv) of such section" and inserting in lieu thereof "months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv)".

(2) SPECIAL ENROLLMENT PERIODS.—Section 1837(i) of the Social Security Act (42 U.S.C. 1395p), as added by section 2338(b) of the Deficit Reduction Act of 1984, is amended—

(A) in paragraph (1), by amending subparagraph (A) to read as follows:

"(A) has attained the age of 65,"; and

(B) in paragraph (2), by redesignating subparagraph (C) as subparagraph (D) and by amending subparagraphs (A) and (B) to read as follows:

"(A) has attained the age of 65;

"(B)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(B);

"(C) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or individual's spouse's) current employment; and".

(3) EFFECTIVE DATES.—

(A) The amendment made by paragraph (1) shall apply to months beginning with January 1983 for premiums for months beginning with the first month that begins more than 30 days after the date of the enactment of this Act.

(B)(i) The amendments made by paragraph (2) shall apply to enrollments in months beginning with the first effective month (as defined in clause (ii)), except that in the case of any individual who would have a special enrollment period under section 1837(i) of the Social Security Act that would have begun after November 1984 and before the first effective month, the period shall be deemed

to begin with the first day of the first effective month.

(ii) For purposes of clause (i), the term "first effective month" means the first month that begins more than 90 days after the date of the enactment of this Act.

(b) MISCELLANEOUS TECHNICAL CORRECTIONS.—

(1)(A) Subclause (III) of section 1842(b)(7)(B)(ii) of the Social Security Act (42 U.S.C. 1395u(b)(7)(B)(ii)), as added by section 2307(a)(2)(G) of the Deficit Reduction Act of 1984, is amended by indenting it two additionals ems to the right so as to align its left margin with the left margins of subclauses (I) and (II) of that section.

(B) Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)), as inserted by section 2321(e)(3) of the Deficit Reduction Act of 1984, is amended by striking out "at his home" and inserting in lieu thereof "as his home".

(C) Section 1888(b) of the Social Security Act (42 U.S.C. 1395yy(b)), as added by section 2319(b) of the Deficit Reduction At of 1984, is amended by striking out "nothwithstanding" and inserting in lieu thereof "notwithstanding".

(D) The amendments made by this paragraph shall be effective as if they had been originally included in the Deficit Reduction Act of 1984.

(2)(A) Clause (iii) of section 1842(b)(7)(B) of the Social Security Act (42 U.S.C. 1395u(b)(7)(B)), as added by section 3(b)(6) of Public Law 98–617, is amended by moving its alignment two additionals ems to the left so as to align its left margin with the left margins of clauses (i) and (ii) of that section.

(B) The amendment made by subparagraph (A) shall be effective as if it had been originally included in Public Law 98–617.

(3)(A) Section 1861(v)(1)(G)(i) of the Social Security Act (42 U.S.C. 1395x(b)(1)(G)(i)), as amended by section 602(d)(1) of the Social Security Amendments of 1983, is amended by inserting, in the matter after subclause (III), "on the basis of" after "(during such period)".

(B) The amendment made by subparagraph (A) shall be effective as if it had been originally included in the Social Security Amendments of 1983.

PART C—CHANGES RELATING PRIMARILY TO PART B OF THE MEDICARE PROGRAM

SEC. 141. EXTENSION OF PHYSICIAN FEE FREEZE FOR NON-PARTICIPATING PHYSICIANS AND IMPROVEMENTS IN THE PARTICIPATING PHYSICIAN PROGRAM.

(a) ONE-YEAR EXTENSION FOR NON-PARTICIPATING PHYSICIANS.—

(1) EXTENSION.—Section 1842(b)(4) of the Social Security Act (42 U.S.C. 1395u(b)(4)) is amended—

(A) in subparagraph (A)—

(i) by inserting "(i)" after "(4)(A)", and

(ii) by adding at the end the following new clauses:

"(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

"(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after October 1, 1986, by a physician who is not a participat-

ing physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous fiscal year for physicians who were participating physicians during that year.";

(B) in subparagraph (B)—

(i) by inserting "(i)" after "(B)", and

(ii) by adding at the end the following new clause:

"(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.";

(C) in subparagraph (C)—

(i) by inserting "(i)" after "(C)",

(ii) by striking out "(A)" and inserting in lieu thereof "(A)(i)" each place it appears, and

(iii) by adding at the end the following new clause:

"(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians'

services furnished during the periods beginning after September 30, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).''; and

(D) in subparagraph (D)—

(i) by striking out ''who at no time'' and all that follows through ''subsection (h)(1))'' and insert in lieu thereof ''who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985'',

(ii) by inserting ''(i)'' after ''(D)'', and

(iii) by adding at the end the following new clause:

''(ii) In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1986, or October 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on September 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 12-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.''.

(2) CONTINUED ENFORCEMENT.—The first sentence of section 1842(j)(1) of such Act (42 U.S.C. 1395u(j)(1)) is amended to read as follows: "In the case of a physician who is not a participating physician for items and services furnished during a portion of the 27-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after October 1, 1985.

(b) INCENTIVES FOR PARTICIPATING PHYSICIAN PROGRAM.—

(1) ONE-YEAR EXTENSION OF TRANSFER OF FUNDS FOR CARRIERS.—Section 2306(e) of the Deficit Reduction Act of 1984 (Public Law 98–369; 98 Stat. 1073) is amended—

(A) by striking out "and 1985" and inserting in lieu thereof ", 1985, and 1986",

(B) by striking out "the amendments made by this section" and inserting in lieu thereof "subsections (b)(4), (h), and (j) of section 1842 of the Social Security Act",

(C) by striking out "for fiscal year 1985" and inserting in lieu thereof "for each of fiscal years 1985 and 1986", and

(D) by adding at the end the following new sentence: "A significant proportion of such funds shall be used for the expansion of the participating physician and supplier program and for the development of professional relations staffs dedicated to addressing the billing and other problems of physicians and suppliers participating in that program.".

(2) IMPROVEMENT OF PARTICIPATING PHYSICIAN DIRECTORIES.—Section 1842(i) of the Social Security Act (42 U.S.C. 1395u(i)) is amended—

(A) in the first sentence of paragraph (2)—

(i) by striking out "a directory" and inserting in lieu thereof "directories (for appropriate local geographic areas)", and

(ii) by inserting "for that area" before "for that fiscal year";

(B) in the second sentence of paragraph (2), by striking out "The directory" and inserting in lieu thereof "Each directory";

(C) in paragraph (3)—

(i) by striking out "directory" the first place it appears and inserting in lieu thereof "the directories", and

(ii) by striking out "directory" the second place it appears and inserting in lieu thereof "the appropriate area directory or directories"; and

(D) in paragraph (4)—

(i) by striking out "directory" and inserting in lieu thereof "the directories", and

(ii) by adding at the end the following: "The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area.".

(3) ELIMINATION OF PHYSICIAN ASSIGNMENT RATE LIST.—Section 1842(i) of such Act is further amended—

(A) by striking out "(i)(1)" and all that follows through the end of paragraph (1),

(B) by striking out "subsection (h)(1)" in paragraph (2) and inserting in lieu thereof "paragraph (1)",

(C) by striking out "such list and" and "the list and" each place either appears in paragraphs (3) and (4), and

(D) by redesignating paragraphs (2) through (4) as paragraphs (4) through (6) of subsection (h), respectively.

(4) INFORMATION ON THE PARTICIPATING PHYSICIAN AND SUPPLIER PROGRAM IN EXPLANATIONS OF MEDICARE BENEFITS FOR UNASSIGNED CLAIMS.—Section 1842(h) of such Act, as previously amended by this subsection, is further amended by adding at the end the following new paragraphs:

"(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis, described in paragraph (8)), shall include—

"(A) a reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers), and

"(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which an individual enrolled under this part may obtain information on participating physicians and suppliers.

"(8) For purposes of this title, a claim is considered to be paid on an 'assignment-related basis' if the claim is paid on the basis of an assignment described in subsection

(b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1).".

(5) EFFECTIVE DATE.—Section 1842(b)(7) of the Social Security Act, as added by paragraph (4) of this subsection, shall apply to explanations of benefits provided on or after such date (not later than April 1, 1986) as the Secretary of Health and Human Services shall specify.

SEC. 142. EXPANSION OF MEMBERSHIP AND DUTIES OF THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION TO INCLUDE REVIEW OF PAYMENTS FOR PHYSICIANS' SERVICES.

(a) EXPANSION AND ESTABLISHMENT OF SUBCOMMITTEES.—

(1) IN GENERAL.—Section 1886(e)(6) of the Social Security Act (42 U.S.C. 1395ww(e)(6)) is amended—

(A) by amending subparagraph (A) to read as follows:

"(A)(i) The Commission shall consist of 23 members. Fifteen members of the Commission shall first be appointed no later than April 1, 1984, and the remaining members shall first be appointed no later than January 1, 1986, for a term of three years, except that the Director may provide for such shorter terms as will insure that (on a continuing basis) the

terms of no more than eight members expire in any one year. The Director shall appoint a member to serve as Chairman.

"(ii) The Chairman of the Commission shall provide for two subcommittees of the Commission, one with functions and responsibilities relating primarily to hospital payment issues and the other with functions and responsibilities relating primarily to physician payment issues. The Chairman may assign members of the Commission to serve on either or both subcommittees of the Commission."; and

(B) in subparagraph (B), by inserting "representatives of consumer and elderly groups," after "third party payors,".

(2) INITIAL ASSIGNMENT OF MEMBERS TO SUBCOMMITTEES.—The Chairman of the Commission shall initially assign—

(A) to serve on the hospital payment subcommittee of the Commission—

(i) all the members of the Commission serving in positions established before the date of the enactment of this Act, and

(ii) two of the members appointed to the Commission for additional positions established by the amendment made by paragraph (1), and

(B) to serve on the physician payment subcommittee of the Commission the six remaining members of the Commission who are appointed to serve in the additional positions so established.

(b) ADDITIONAL FUNCTIONS RELATING TO PHYSICIANS' PAYMENTS.—Section 1886(e) of such Act is amended by adding at the end the following new paragraph:

"(7)(A) The Commission shall make recommendations to the Congress, not later than February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under part B.

"(B) In making its recommendations, the Commission shall—

"(i) consider, and make recommendations on the feasibility and desirability of reducing, the differences in payment amounts for physicians' services under part B which are based on differences in geographic location or specialty;

"(ii) review the input costs (including time, professional skills, and risks) associated with the provision of different physicians' services;

"(iii) identify those charges recognized as reasonable under section 1842(b) which are significantly out-of-line, based on the considerations of clauses (i) and (ii);

"(iv) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

"(v) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under part B on an assignment-related basis;

"(vi) make recommendations respecting the advisability and feasibility of making changes in the payment system for physicians' services under part B based on (I) the Secretary's study under section 603(b)(2) of the Social Security Amendments of 1983 (relating to payments for physicians' services furnished to hospital inpatients on the basis of diagnosis-related groups) and (II) the Office's report under section 2309 of the Deficit Reduction Act of 1984 (relating to physician reimbursement under part B);

"(vii) identify those procedures, involving the use of assistants at surgery, for which payment for those

assistants should not be made under this title without prior approval; and

"(viii) identify those procedures for which an opinion of a second physician should be required before payment is made under this title.

"(C) The Commission also shall advise and make recommendations to the Secretary respecting the development of the relative value scale under section 1845.".

(c) STUDY OF RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES.—Part B of title XVIII of such Act is amended by adding at the end the following new section:

"STUDY OF RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES

"SEC. 1845. (a) The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under this part.

"(b) In developing the scale, the Secretary shall consider among other items—

"(1) the report of the Office of Technology Assessment under section 2309 of the Deficit Reduction Act of 1984,

"(2) the recommendations of the Prospective Payment Assessment Commission under section 1886(e)(7)(C), and

"(3) factors with respect to the input costs for furnishing particular physicians' services, such as—

"(A) the differences in costs of furnishing services in different settings,

"(B) the differences in skill levels and training required to perform the services, and

"(C) the time required, and risk involved, in furnishing different services.

"(c) The Secretary shall complete the development of the relative value scale under this section, and report to Congress on the development, not later than April 1, 1987. The report shall include recommendations for the application of the scale to the payment for physicians' services furnished under this part on or after October 1, 1987.".

(d) MODIFICATION OF FUNDING FORMULA.—Section 1886(e)(6)(I)(ii) of such Act is amended by striking out "Eighty-five" and "15" and inserting in lieu thereof "Fifty" and "50".

(e) STAFFING.—Section 1886(e)(6)(C)(i) of such Act is amended by striking out "25" and inserting in lieu thereof "35".

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 1985.

SEC. 143. PART B PREMIUM.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (e), by striking out "1988" and inserting in lieu thereof "1989" each place it appears;

(2) in subsection (f)(1), by striking out "or 1986" and inserting in lieu thereof ", 1986, or 1987"; and

(3) in subsection (f)(2), by striking out "or 1987" and inserting in lieu thereof ", 1987, or 1988".

SEC. 144. DETERMINATIONS OF INHERENT REASONABLENESS OF CHARGES AND CUSTOMARY CHARGES FOR CERTAIN FORMER HOSPITAL-COMPENSATED PHYSICIANS.

(a) REGULATIONS RELATING TO INHERENT REASONABLENESS OF CHARGES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

"(8) The Secretary by regulation shall—

"(A) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

"(B) provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.".

(b) COMPUTATION OF CUSTOMARY CHARGES FOR CERTAIN FORMER HOSPITAL-COMPENSATED PHYSICIANS.—(1) In applying section 1842(b) of the Social Security Act for payment for physicians' services performed during fiscal year 1986, in the case of a physician who during the period beginning on October 31, 1982, and ending on January 31, 1985, was a hospital-compensated physician (as defined in paragraph (2)) but who, as of January 31, 1985, was no longer a hospital-compensated physician, the physician's customary charges shall—

(A) be based upon the physician's actual charges billed during the 12-month period ending on March 31, 1985, and

(B) in the case of a physician who is not a participating physician (as defined in section 1842(h)(1) of the Social Security Act) on October 1, 1985, be deflated (to take into account the legislative freeze on actual charges for nonparticipating physicians' services) by multiplying the physician's customary charges by .83.

(2) In paragraph (1), the term "hospital-compensated physician" means, with respect to services furnished to patients of a hospital, a physician who is compensated by the

hospital for the furnishing of physicians' services for which payment may be made under this part.

SEC. 145. OCCUPATIONAL THERAPY SERVICES.

(a) COVERAGE.—Subparagraph (C) of section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended to read as follows:

"(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));".

(b) LIMITATION ON PAYMENTS.—Section 1833(g) of such Act (42 U.S.C. 1395l(g)) is amended—

(1) by striking out "next to last sentence" and inserting in lieu thereof "second sentence", and

(2) by adding at the end thereof the following new sentence: "In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).".

(c) CERTIFICATION STANDARD.—(1) Section 1835(a)(2)(C) of such Act (42 U.S.C. 1395n(a)(2)(C)) is amended—

(A) by inserting "or outpatient occupational therapy services" after "outpatient physical therapy services",

(B) in clause (i), by inserting "or occupational therapy services, respectively" after "physical therapy services", and

(C) in clause (ii), by inserting "or qualified occupational therapist, respectively" after "qualified physical therapist".

(2) The second sentence of section 1835(a) of such Act and section 1866(e) of such Act (42 U.S.C. 1395n(a), 1395cc(e)) are each amended—

(A) by inserting "(or meets the requirements of such section through the operation of section 1861(g))" after "1861(p)(4)(A)" and after "1861(p)(4)(B)", and

(B) by inserting "or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services" after "(as therein defined)".

(d) DEFINITION AND INCLUSION WITH OTHER PART B SERVICES.—(1) Section 1861 of the Social Security Act (42

U.S.C. 1395x) is amended by inserting after subsection (f) the following new subsection:

"Outpatient Occupational Therapy Services

"(g) The term 'outpatient occupational therapy services' has the meaning given the term 'outpatient physical therapy services' in subsection (p), except that 'occupational' shall be substituted for 'physical' each place it appears therein.".

(2) Section 1861(s)(2)(D) of such Act (42 U.S.C. 1395x(s)(2)(D)) is amended by inserting "and outpatient occupational therapy services" after "outpatient physical therapy services".

(3) Section 1861(v)(5)(A) of such Act (42 U.S.C. 1395x(v)(5)(A)) is amended by inserting "(including through the operation of section 1861(g))" after "section 1861(p)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred for outpatient occupational therapy services furnished on or after October 1, 1985.

SEC. 146. PAYMENT FOR DURABLE MEDICAL EQUIPMENT.

(a) LIMITING TO ONE PERCENT INCREASES IN CUSTOMARY AND PREVAILING CHARGES FOR DURABLE MEDICAL EQUIPMENT FURNISHED ON RENTAL BASIS.—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

"(k)(1) In determining the customary and prevailing charge levels under the third and fourth sentences of subsection (b)(3) for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) during the 12-month period beginning on October 1, 1985, the Secretary shall not set any such level higher than 101 percent of the same level as was set for the 15-month period beginning July 1, 1984.".

(b) REQUIRING PAYMENT ON AN ASSIGNMENT BASIS FOR DURABLE MEDICAL EQUIPMENT FURNISHED ON A RENTAL BASIS.—Section 1842(k) of such Act, as added by subsection (a), is amended by adding at the end the following new paragraph:

"(2) Payment under this part for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) may only be made on an assignment-related basis (as defined in subsection (h)(8)) or to a provider of services with an agreement in effect under section 1866.".

(c) LIMITING INCREASE IN PREVAILING CHARGES FOR DURABLE MEDICAL EQUIPMENT TO CONSUMER PRICE INDEX.—Section 1842(k) of such Act, as previously amended, is further amended by adding at the end the following new paragraph:

"(3) In the case of durable medical equipment, the prevailing charge levels determined for purposes of clause (ii) of

the third sentence of subsection (b) for any 12-month period (beginning after September 30, 1986) may not exceed (in the aggregate) the levels determined under such clause (taking into account paragraph (1), if applicable) for the preceding 12-month period by a percentage which exceeds the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average), as published by the Secretary of Labor, for the 12-month period ending in March of that preceding 12-month period.''.

(d) CLARIFICATION OF PREVIOUS EFFECTIVE DATE.—Section 2306(b)(2) of the Deficit Reduction Act of 1984 is amended by adding before the period at the end the following: ''and to durable medical equipment furnished on or after July 1, 1985''.

(e) EFFECTIVE DATES.—

(1) SUBSECTION (a).—The amendments made by subsection (a) shall apply to durable medical equipment furnished on or after October 1, 1985.

(2) SUBSECTION (b).—The amendments made by subsection (b) shall apply to durable medical equipment furnished on or after January 1, 1986.

(3) SUBSECTION (c).—The amendments made by subsection (c) shall apply to durable medical equipment furnished on or after October 1, 1986.

(4) SUBSECTION (d).—The amendment made by subsection (d) shall take effect as though it were included in the enactment of the Deficit Reduction Act of 1984.

SEC. 147. PAYMENT FOR ASSISTANTS AT SURGERY FOR CERTAIN CATARACT OPERATIONS AND OTHER OPERATIONS.

(a) LIMITATION ON PAYMENT.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) by striking out "or" at the end of paragraph (13),

(2) by striking out the period at the end of paragraph (14) and inserting in lieu thereof "; or", and

(3) by adding at the end the following new paragraph:

"(15) which are for services of an assistant at surgery in a cataract operation unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition.".

(b) ADDITIONAL PRO FUNCTIONS.—Section 1154(a)(8) of such Act (42 U.S.C. 1320c–3(a)(8)) is amended by insert-

ing before the period at the end the following: "or as may be required to carry out section 1862(a)(15)".

(c) PROHIBITION FOR SUBMITTING BILL FOR WHICH PAYMENT MAY NOT BE MADE.—Section 1842 of such Act (42 U.S.C. 1395u) is amended—

(1) in subsection (j)(2), by inserting "or subsection (l)" after "paragraph (1)", and

(2) by adding after subsection (k), added by section 146(a) of this title, the following new subsection:

"(l)(1) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(2) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).".

(d) EXTENSION OF PROHIBITION TO OTHER PROCEDURES.—The Secretary of Health and Human Services, after consultation with the Prospective Payment Assessment Commission, shall develop recommendations and guidelines

respecting other surgical procedures for which an assistant at surgery is generally not medically necessary and the circumstances under which the use of an assistant at surgery is medically appropriate with prior approval of an appropriate entity. The Secretary shall report to Congress, not later than April 1, 1986, on these recommendations and guidelines.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services performed on or after October 1, 1985.

SEC. 148. LIMITATION ON MEDICARE PAYMENT FOR POST-CATARACT SURGERY PATIENTS.

(a) PAYMENT FOR REPLACEMENT OF LOST OR DAMAGED CATARACT EYEGLASSES AND CATARACT CONTACT LENSES.—With respect to the payment for replacement cataract eyeglasses and cataract contact lenses under title XVIII of the Social Security Act in the case of an individual beneficiary—

(1) payment may be made for the replacement only once every year of lost or damaged cataract eyeglasses, and

(2) payment may be made—

(A) in the first year after surgery, for one original cataract contact lens for each eye and for the replacement only twice of a lost or damaged cataract contact lens for each eye, and

(B) in each subsequent year, for the replacement only twice of a lost or damaged cataract contact lens for each eye.

(b) DETERMINATION OF SEPARATE PAYMENT AMOUNTS FOR PROSTHETIC LENSES AND PROFESSIONAL SERVICES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding after paragraph (8), added by section 144(a) of this Act, the following new paragraph:

"(9) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

"(A) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services, and

"(B) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.".

(c) EFFECTIVE DATE.—(1) The amendments made by this section shall apply to items and services furnished on or after October 1, 1985.

(2) In applying the amendment made by subsection (a), there shall not be taken into account any cataract eyeglasses or contact lenses replaced before October 1, 1985.

SEC. 149. DEMONSTRATION OF PREVENTIVE HEALTH SERVICES UNDER MEDICARE.

(a) DEMONSTRATION PROGRAM.—The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a demonstration program designed to reduce disability and dependency through the provision of preventive health services to individuals entitled to benefits under title XVIII of the Social Security Act (hereinafter in this section referred to as "medicare beneficiaries").

(b) PREVENTIVE HEALTH SERVICES UNDER DEMONSTRATION PROGRAM.—The preventive health services to be made available under the demonstration program shall include—

(1) health screenings,

(2) health risk appraisals,

(3) immunizations, and

(4) counseling on and instruction in—

(A) diet and nutrition,

(B) reduction of stress,

(C) exercise and exercise programs,

(D) sleep regulation,

(E) injury prevention,

(F) prevention of alcohol and drug abuse,

(G) prevention of mental health disorders,

(H) self-care, including use of medication, and

(I) reduction of smoking.

(c) CONDUCT OF PROGRAM.—The demonstration program shall—

(1) be conducted under the direction of accredited public or private nonprofit schools of public health;

(2) be conducted in no fewer than five sites, which sites shall be chosen so as to be geographically diverse and shall be readily accessible to a significant number of medicare beneficiaries;

(3) involve community outreach efforts at each site to enroll the maximum number of medicare beneficiaries in the program; and

(4) be designed—

(A) to test alternative methods of payment for preventive health services, including payment on a prepayment basis as well as payment on a fee-for-service basis,

(B) to permit a variety of appropriate health care providers to furnish preventive health services, including physicians, health educators,

nurses, allied health personnel, dieticians, and clinical psychologists, and

(C) to facilitate evaluation under subsection (d).

(d) EVALUATION.—The Secretary shall evaluate the demonstration project in order to determine—

(1) the short-term and long-term costs and benefits of providing preventive health services for medicare beneficiaries, including any reduction in inpatient services resulting from providing the services, and

(2) what practical financing mechanisms exist to provide payment for preventive health services under title XVIII of the Social Security Act.

(e) REPORTS TO CONGRESS.—(1) Not later than three years after the date of the enactment of this Act, the Secretary shall submit a preliminary report to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate on the progress made in the demonstration program, including a description of the sites at which the program is being conducted and the preventive health services being provided at the different sites.

(2) Not later than five years after the date of the enactment of this Act, the Secretary shall submit a final report to those Committees on the demonstration program and shall include in the report—

(A) the evaluation described in subsection (d), and

(B) recommendations for appropriate legislative changes to incorporate payment for cost-effective preventive health services into the medicare program.

(f) FUNDING.—Expenditures made for the demonstration program shall be made from the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

(g) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

PART D—OTHER AND ADDITIONAL CHANGES RELATING TO PART B (OR TO PARTS A AND B) OF THE MEDICARE PROGRAM

SEC. 151. EXTENSION OF PHYSICIAN FEE FREEZE FOR CERTAIN NON-PARTICIPATING PHYSICIANS AND IMPROVEMENTS IN THE PARTICIPATING PHYSICIAN PROGRAM.

(a) ONE-YEAR EXTENSION FOR NON-PARTICIPATING PHYSICIANS.—

(1) EXTENSION.—Section 1842(b)(4) of the Social Security Act (42 U.S.C. 1395u(b)(4)) is amended—

(A) in subparagraph (A)—

(i) by inserting "(i)" after "(4)(A)", and

(ii) by adding at the end the following new clauses:

"(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983; except that in the case of a physician described in subparagraph (E)(i), the Secretary shall not set any level higher than the increase percentage (described in

subparagraph (E)(ii)) above the level that was set for the 12-month period beginning July 1, 1983.

"(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after October 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous fiscal year for physicians who were participating physicians on the last day of that year; except that in the case of a physician described in subparagraph (E)(i), the Secretary shall not set any level higher than the increase percentage (described in subparagraph (E)(ii)) above the level that was set for services furnished during the previous fiscal year for physicians who were participating physicians on the last day of that year.";

(B) in subparagraph (B)—

(i) by inserting "(i)" after "(B)", and

(ii) by adding at the end the following new clause:

"(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection

(h)(1)) at the time of furnishing the services, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983; except that in the case of a physician described in subparagraph (E)(i), the customary charges may not exceed the customary charges that were recognized under this section for the 12-month period beginning July 1, 1983, increased by the increase percentage (described in subparagraph (E)(ii)).'';

(C) in subparagraph (C)—

(i) by inserting ''(i)'' after ''(C)'',

(ii) by striking out ''(A)'' and inserting in lieu thereof ''(A)(i)'' each place it appears, and

(iii) by adding at the end the following new clause:

''(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).'';

(D) in subparagraph (D)—

(i) by striking out "who at no time" and all that follows through "subsection (h)(1))" and insert in lieu thereof "who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985",

(ii) by inserting "(i)" after "(D)", and

(iii) by adding at the end the following new clause:

"(ii)(I) In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1986, or October 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on September 30, 1986, except as provided in subclause (II) the Secretary shall not recognize increases in actual charges for services furnished during the 12-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

"(II) In the case of a physician who was a participating physician on September 30, 1985, the Secretary shall recognize increases in actual charges for services furnished during the 12-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984, but only to the extent that the percentage of such an increase does not

exceed one-half of the percentage increase in the physician's actual charges for services furnished over the period beginning July 1, 1984, and ending September 30, 1985."; and

(E) by adding at the end the following new subparagraph:

"(E)(i) With respect to services furnished during a 12-month period beginning on October 1, a physician described in this clause is a physician who is not a participating physician at the time of furnishing the services but who either (I) was a participating physician on September 30 before that period, or (II) accepted payment on an assignment-related basis (as defined in subsection (h)(8)) for all claims received during the immediately preceding 12-month period for services furnished by the physician under this part during that period.

"(ii) The 'increase percentage' described in this clause is, with respect to a physician for items and services furnished during a 12-month period beginning on October 1, one-half of the percentage increase that otherwise would be applicable to services furnished by the physician if the physician (I) had been a participating physician on the date before the first date of the period, and (II) were to sign up to be a participating physician for items and services furnished during the period.".

(2) CONTINUED ENFORCEMENT.—Section 1842(j)(1) of such Act (42 U.S.C. 1395u(j)(1)) is amended—

(A) by amending the first sentence to read as follows: "In the case of a physician who is not a participating physician for items and services furnished during a portion of the 27-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period."; and

(B) in the second sentence, by inserting ", or, in the case of items and services furnished during fiscal year 1986 by a physician who was a participating physician on September 30, 1985, if such physician knowingly and willfully bills individuals enrolled under this part for actual charges which are more than the increase percentage (which may be recognized under subparagraph (D)(ii)(II)) above such physician's actual charges for the calendar quarter beginning on April 1, 1984" after "April 1, 1984".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after October 1, 1985.

(b) INCENTIVES FOR PARTICIPATING PHYSICIAN PROGRAM.—

(1) ONE-YEAR EXTENSION OF TRANSFER OF FUNDS FOR CARRIERS.—Section 2306(e) of the Deficit Reduction Act of 1984 (Public Law 98–369; 98 Stat. 1073) is amended—

(A) by striking out "and 1985" and inserting in lieu thereof ", 1985, and 1986",

(B) by striking out "the amendments made by this section" and inserting in lieu thereof "subsections (b)(4), (h), and (j) of section 1842 of the Social Security Act",

(C) by striking out "for fiscal year 1985" and inserting in lieu thereof "for each of fiscal years 1985 and 1986", and

(D) by adding at the end the following new sentence: "A significant proportion of such funds shall be used for the expansion of the participating physician and supplier program and for the development of professional relations staffs dedicated to addressing the billing and other problems of physicians and suppliers participating in that program.".

(2) IMPROVEMENT OF PARTICIPATING PHYSICIAN DIRECTORIES.—Section 1842(i) of the Social Security Act (42 U.S.C. 1395u(i)) is amended—

(A) in the first sentence of paragraph (2)—

(i) by striking out "a directory" and inserting in lieu thereof "directories (for appropriate local geographic areas)", and

(ii) by inserting "for that area" before "for that fiscal year";

(B) in the second sentence of paragraph (2), by striking out "The directory" and inserting in lieu thereof "Each directory";

(C) in paragraph (3)—

(i) by striking out "directory" the first place it appears and inserting in lieu thereof "the directories", and

(ii) by striking out "directory" the second place it appears and inserting in lieu thereof "the appropriate area directory or directories";

(D) in paragraph (4)—

(i) by striking out "directory" and inserting in lieu thereof "the directories", and

(ii) by adding at the end the following: "The Secretary shall provide that each ap-

propriate area directory is sent to each participating physician located in that area.''.

(3) ELIMINATION OF PHYSICIAN ASSIGNMENT RATE LIST.—Section 1842(i) of such Act is further amended—

(A) by striking out ''(i)(1)'' and all that follows through the end of paragraph (1),

(B) by striking out ''subsection (h)(1)'' in paragraph (2) and inserting in lieu thereof ''paragraph (1)'',

(C) by striking out ''such list and'' and ''the list and'' each place either appears in paragraphs (3) and (4), and

(D) by redesignating paragraphs (2) through (4) as paragraphs (4) through (6) of subsection (h), respectively.

(4) INFORMATION ON THE PARTICIPATING PHYSICIAN AND SUPPLIER PROGRAM IN EXPLANATIONS OF MEDICARE BENEFITS FOR UNASSIGNED CLAIMS.—Section 1842(h) of such Act, as previously amended by this subsection, is further amended by adding at the end the following new paragraphs:

''(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims

under section 1833(a)(1) (made other than on an assignment-related basis, described in paragraph (8)), shall include—

"(A) a reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers), and

"(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which a beneficiary may obtain information on participating physicians and suppliers.

"(8) For purposes of this title, a claim is considered to be paid on an 'assignment-related basis' if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1).".

(5) EFFECTIVE DATE.—Section 1842(b)(7) of the Social Security Act, as added by paragraph (4) of this subsection, shall apply to explanations of benefits provided on or after such date (not later than April 1, 1986) as the Secretary of Health and Human Services shall specify.

SEC. 152. PHYSICIAN PAYMENT REVIEW COMMISSION AND DEVELOPMENT OF RELATIVE VALUE SCALE.

(a) ESTABLISHMENT OF COMMISSION.—Part B of title XVIII of the Social Security Act is amended by adding at the end the following new section:

"PHYSICIAN PAYMENT REVIEW COMMISSION

"SEC. 1845. (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to the the 'Director' and the 'Office', respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of physicians' services appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed no later than December 1, 1985, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

"(3) The membership of the Commission shall include physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of con-

sumers and the elderly. The Director shall seek nominations from a wide range of groups, including—

"(A) national organizations representing physicians, including medical specialty organizations,

"(B) organizations representing the elderly and consumers,

"(C) national organizations representing medical schools,

"(D) national organizations representing hospitals, including teaching hospitals, and

"(E) national organizations representing health benefits programs.

"(b)(1) The Commission shall make recommendations to the Congress, not later than February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under this part.

"(2) In making its recommendations, the Commission shall—

"(A) consider, and make recommendations on the feasibility and desirability of reducing, the differences in payment amounts for physicians' services under this

part which are based on differences in geographic location or specialty;

"(B) review the input costs (including time, professional skills, and risks) associated with the provision of different physicians' services;

"(C) identify those charges recognized as reasonable under section 1842(b) which are significantly out-of-line, based on the considerations of subparagraphs (A) and (B);

"(D) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

"(E) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

"(F) make recommendations respecting the advisability and feasibility of making changes in the payment system for physicians' services under this part based on (i) the Secretary's study under section 603(b)(2) of the Social Security Amendments of 1983 (relating to payments for physicians' services furnished to hospital inpatients on the basis of diagnosis-related

groups) and (ii) the Office's report under section 2309 of the Deficit Reduction Act of 1984 (relating to physician reimbursement under this part);

"(G) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval;

"(H) identify those procedures for which an opinion of a second physician should be required before payment is made under this title; and

"(I) evaluate the method for calculating the number of full-time-equivalent residents set forth in section 1902(h)(4)(D) and make recommendations regarding revisions in, or alternatives to, that method.

"(3) The Commission also shall advise and make recommendations to the Secretary respecting the development of the relative value scale under subsection (e).

"(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

"(A) Subparagraph (C) (relating to staffing and administration generally).

"(B) Subparagraph (D) (relating to compensation of members).

"(C) Subparagraph (F) (relating to access to information).

"(D) Subparagraph (G) (relating to reports and use of funds).

"(E) Subparagraph (H) (relating to periodic GAO audits).

"(F) Subparagraph (J) (relating to requests for appropriations).

"(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall—

"(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate for the development of useful and valid guidelines by the Commission, and

"(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treatment modalities), which in-

formation the Commission shall consider in making reports and recommendations to the Secretary and Congress.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.".

(b) DEVELOPMENT OF RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES.—Section 1845 of the Social Security Act, as added by subsection (a), is further amended by adding at the end the following new subsection:

"(e)(1) The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under this part or under State plans approved under title XIX.

"(2) In developing the scale, the Secretary shall consider among other items—

"(A) the report of the Office of Technology Assessment under section 2309 of the Deficit Reduction Act of 1984,

"(B) the recommendations of the Physician Payment Review Commission under subsection (b)(3), and

"(C) factors with respect to the input costs for furnishing particular physicians' services, such as—

"(i) the differences in costs of furnishing services in different settings,

"(ii) the differences in skill levels and training required to perform the services, and

"(iii) the time required, and risk involved, in furnishing different services.

"(3) The Secretary shall complete the development of the relative value scale under this section, and report to Congress on the development, not later than April 1, 1987. The report shall include recommendations for the application of the scale to payment for physicians' services furnished under this part on or after October 1, 1987.".

SEC. 153. PAYMENT FOR DURABLE MEDICAL EQUIPMENT.

(a) FREEZING CUSTOMARY AND PREVAILING CHARGES FOR ITEMS FURNISHED ON RENTAL BASIS AND HOME OXYGEN SERVICES.—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

"(k)(1) In determining the customary and prevailing charge levels under the third and fourth sentences of subsection (b)(3)—

"(A) for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement), and

"(B) for oxygen therapy services furnished,

during the 12-month period beginning on October 1, 1985, the Secretary shall not set any such level higher than the same level as was set for the 15-month period beginning July 1, 1984. As used in this subsection, the term 'oxygen therapy services' means durable medical equipment, accessories, and supplies for the provision of oxygen therapy in a patient's home.".

(b) REQUIRING PAYMENT ON AN ASSIGNMENT BASIS FOR DURABLE MEDICAL EQUIPMENT FURNISHED ON A RENTAL BASIS AND FOR OXYGEN THERAPY SERVICES.—Section 1842(k) of such Act, as added by subsection (a), is amended by adding at the end the following new paragraph:

"(2) Payment under this part for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) and for oxygen therapy services may only be made on an assignment-related basis (as defined in subsection (h)(8)) or to a provider of services with an agreement in effect under section 1866.".

(c) LIMITING INCREASE IN PREVAILING CHARGES FOR DURABLE MEDICAL EQUIPMENT TO CONSUMER PRICE INDEX.—Section 1842(k) of such Act, as previously amended, is further amended by adding at the end the following new paragraph:

"(3) In the case of durable medical equipment, the prevailing charge levels determined for purposes of clause (ii) of

the third sentence of subsection (b) for any 12-month period (beginning after September 30, 1986) may not exceed (in the aggregate) the levels determined under such clause (taking into account paragraph (1), if applicable) for the preceding 12-month period by a percentage which exceeds the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average), as published by the Secretary of Labor, for the 12-month period ending in March of that preceding 12-month period.''.

(d) CLARIFICATION OF PREVIOUS EFFECTIVE DATE.—Section 2306(b)(2) of the Deficit Reduction Act of 1984 is amended by adding before the period at the end the following: ''and to durable medical equipment furnished on or after July 1, 1985''.

(e) EFFECTIVE DATES.—

(1) SUBSECTION (a).—The amendments made by subsection (a) shall apply to durable medical equipment (including oxygen therapy services) furnished on or after October 1, 1985.

(2) SUBSECTION (b).—The amendments made by subsection (b) shall apply to durable medical equipment furnished on or after January 1, 1986.

(3) SUBSECTION (c).—The amendments made by subsection (c) shall apply to durable medical equipment furnished on or after October 1, 1986.

(4) SUBSECTION (d).—The amendment made by subsection (d) shall take effect as though it were included in the enactment of the Deficit Reduction Act of 1984.

SEC. 154. PAYMENT FOR CLINICAL LABORATORY SERVICES.

(a) CHANGING MONTH OF ANNUAL UPDATE FROM JULY TO OCTOBER.—

(1) IN GENERAL.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

(A) by striking out "June 30, 1987" and "July 1, 1987" and inserting in lieu thereof "September 30, 1987" and "October 1, 1987", respectively, each place either appears, and

(B) in paragraph (2), by inserting "(to become effective on October 1 of each year)" after "adjusted annually".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to clinical laboratory diagnostic tests performed on or after July 1, 1986.

(3) TRANSITION.—The Secretary of Health and Human Service shall provide that the annual adjustment under section 1833(h) of the Social Security Act for 1986—

(A) shall take effect on October 1, 1986,

(B) shall apply for the 12-month period beginning on that date, and

(C) shall take into account the percentage increase or decrease in the Consumer Price Index for all urban consumers (United States city average) occurring over a 15-month period, rather than over a 12-month period.

(b) PROVIDING CEILING ON RATES.—

(1) CEILING ON PAYMENTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) are each amended by inserting after "lesser of the amount determined under such fee schedule" the following: ", the limitation amount for that test determined under subsection (h)(4)(B),".

(2) ESTABLISHMENT OF LIMITATION AMOUNT.—Section 1833(h)(4) of such Act is amended by inserting "(A)" after "(4)" and by adding at the end the following new subparagraph:

"(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

"(i) on or after January 1, 1986, and before October 1, 1986, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1), or

"(ii) after September 30, 1986, and so long as a fee schedule for the test has not been established on a nationwide basis, is equal to 110 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to clinical diagnostic laboratory tests performed on or after January 1, 1986.

(c) REPORT ON MINIMUM STANDARDS FOR CLINICAL LABORATORIES THAT ARE PART OF, OR ASSOCIATED WITH, PHYSICIANS' OFFICES.—The Secretary of Health and Human Services shall report to Congress, not later than 12 months after the date of the enactment of this Act, on the standards that might be established under the medicare program for clinical laboratories which are part of or associated with a physician's office to assure the health and safety of individuals with respect to whom the laboratories perform clinical diagnostic laboratory tests for which payment may be made under the program. In recommending standards, the Secretary shall consider the differences in the scope, type, and complexity of tests performed by such laboratories and such other factors as may indicate a need for different standards for laboratories with different characteristics.

SEC. 155. VISION CARE.

(a) DEFINING SERVICES AN OPTOMETRIST CAN PROVIDE.—Clause (4) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) is amended to read as follows: "(4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1986.

SEC. 156. SECOND OPINIONS.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

"SECOND OPINIONS FOR CERTAIN SURGICAL PROCEDURES

"SEC. 1890. (a) CONDITION OF PAYMENT.—No payment shall be made under part A or part B with respect to items or services furnished in connection with a surgical procedure listed by the Secretary pursuant to this section unless the individual undergoing the procedure obtains a second opinion as to the necessity and appropriateness of such procedure, in accordance with this section. For purposes of determining whether an opinion is the second opinion, the first opinion must be made by a physician who is qualified to perform the surgical procedure, and the second opinion is any

subsequent opinion made by a physician of the appropriate speciality, as determined under subsection (b)(3). Such second opinion need not necessarily agree with the first opinion in order for payment to be made.

"(b) SURGICAL PROCEDURES TO WHICH CONDITION APPLIES.—

"(1) SECRETARY TO ESTABLISH LIST.—The Secretary shall establish a list of not less than 10 surgical procedures to which the requirements of this section shall apply. The Secretary shall establish such list based upon the following criteria:

"(A) The procedure is one which generally can be postponed without undue risk to the patient.

"(B) The procedure is a high volume procedure among patients who are covered under the programs established under this title, or is a high cost procedure.

"(C) The procedure has a comparatively high rate of nonconfirmation upon requesting a second opinion, based upon data available to the Secretary from any sources.

"(2) LIST VARIATIONS.—The Secretary may vary the list on a State-by-State basis, or within areas of a State, if data available with regard to volume and costs

of procedures suggest that to do so would be cost effective and would better serve the purposes of this section.

"(3) LIST TO SPECIFY SPECIALISTS WHO MUST RENDER SECOND OPINION.—The Secretary shall specify, for each procedure on a list established under this subsection, the type or types of board certified or board eligible specialists who must be consulted for the second opinion, based upon the nature of the procedure.

"(c) REFERRAL MECHANISM FOR SECOND OPINIONS.—

"(1) USE OF PRO AS REFERRAL CENTER.—The Secretary shall enter into or modify contracts with utilization and quality control peer review organizations under which such organizations shall serve as referral centers for second opinions required under this section.

"(2) REFERRAL OF PATIENT.—The organization shall maintain a list of physicians qualified to provide a second opinion and shall advise the patient as to which physicians are participating physicians (within the meaning of section 1842(h)) and which physicians have agreed to accept assignment for second opinions. If the patient seeking the second opinion so requests, the organization shall refer such patient to a physician of the

appropriate specialty for purposes of providing the second opinion.

"(3) FREEDOM OF CHOICE OF PATIENT TO CHOOSE PHYSICIAN.—Subject to paragraph (4), the patient may choose any physician of the proper specialty to provide the second opinion.

"(4) PHYSICIANS PROHIBITED FROM PROVIDING SECOND OPINION.—For purposes of this section, a second opinion may not be provided by a physician who is affiliated with, or has any direct or indirect common financial interest with, the physician who rendered the first opinion that the procedure was necessary.

"(5) FORWARDING OF RELEVANT MEDICAL RECORDS.—Each such organization shall, if the patient seeking the second opinion so requests, obtain the relevant medical records from the physician who rendered the first opinion that the procedure was necessary, and provide the relevant information to the physician selected by the patient to render the second opinion in such form so as not to identify the physician who rendered the first opinion.

"(6) USE OF OTHER ENTITIES AS REFERRAL CENTERS.—(A) If no utilization and quality control peer review organization is available to perform the

functions described in this subsection, the Secretary may enter into an agreement with a State or local agency or appropriate private entity to perform such functions.

"(B) If a State is utilizing an entity other than a utilization and quality control peer review organization to provide referrals for second opinions for purposes of title XIX, the Secretary may enter into an agreement under this section with such entity (rather than with a utilization and quality control peer review organization) to perform the functions described in this section if the Secretary determines that such arrangement would be more cost effective and would adequately protect the patients receiving benefits under this title.

"(C) If the Secretary determines that a utilization and quality control peer review organization is not able to perform the referral services described in this subsection in a manner that adequately protects patients, the Secretary may enter into an agreement with a State or local agency or appropriate private entity to perform such functions.

"(d) EXCEPTIONS TO REQUIREMENT.—The requirements of this section shall not apply—

"(1) if delay in providing the surgical procedure would result in a risk to the patient;

"(2) if no physician is available (within such reasonable limits as the Secretary shall determine by regulation) who is (A) an appropriate specialist, and (B) a participating physician or a physician who has agreed to accept assignment for the second opinion; or

"(3) the surgical procedure is to be performed on a patient who is a member of a health maintenance organization or competitive medical plan having a risk-sharing contract with the Secretary under section 1876(g).

"(e) DUTIES OF PHYSICIANS, HOSPITALS, AND AMBULATORY SURGICAL CENTERS TO NOTIFY PATIENTS.—

"(1) NOTICE.—Any physician, before performing a surgical procedure which requires a second opinion pursuant to this section, and any hospital or ambulatory surgical center, before a patient is furnished services at the hospital or center in connection with the performance of such a procedure, shall inform the patient in writing of the necessity of obtaining a second opinion, and make available to the patient, or to the entity performing referral services under subsection (c) if so requested by the patient, any medical records available to such physician, hospital, or center that are necessary in order for the patient to obtain such second opinion.

"(2) SANCTIONS.—(A) In the case of any physician, hospital, or ambulatory surgical center which fails to notify a patient of the need to obtain a second opinion or fails to make available medical records, as required under paragraph (1), the Secretary may—

"(i) impose a civil monetary penalty and assessment, in the same manner as such penalties are authorized under section 1128A(a), or

"(ii) in the case of a second or subsequent failure, bar the physician, hospital, or ambulatory surgical center from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d),

or both. No payment may be made under this title with respect to any item or service furnished by a physician, hospital, or ambulatory surgical center during the period when it is barred from participation in the program under this title pursuant to this subsection.

"(B) The Secretary may not bar a physician, hospital, or ambulatory surgical center pursuant to subparagraph (A) if such physician, hospital, or ambulatory surgical center is a sole source of essential services in a community.

"(C) The Secretary shall take into account access of beneficiaries to physicians' services, hospital services, and other surgical facility services for which payment may be made under this title in determining whether to bar a physician, hospital, or ambulatory surgical center from participation pursuant to subparagraph (A).

"(D) In any case where payment under this title is denied by reason of this section, and a physician, hospital, or ambulatory surgical center failed to notify the patient as required by paragraph (1), the Secretary shall, out of any civil monetary penalty or assessment collected from such physician, hospital, or ambulatory surgical center pursuant to this subsection, make a payment to the patient in the nature of restitution for amounts paid by such patient to such physician, hospital, or ambulatory surgical center which otherwise would have been paid under this title.

"(f) NOTICE BY SECRETARY.—

"(1) NOTICE TO PHYSICIANS, HOSPITALS, AND AMBULATORY SURGICAL CENTERS.—The Secretary shall notify all physicians, all hospitals having agreements under section 1866, and all ambulatory surgical centers having an agreement with the Secretary described in section 1832(a)(2)(F) of the requirements of

this section. The notice shall include the applicable list of surgical procedures to which such requirements apply, and a description of the penalties for failure to notify a patient concerning such requirements.

"(2) NOTICE TO BENEFICIARIES.—The Secretary shall provide for periodic notice to all beneficiaries under this title of the requirements of this section, including the applicable list of the surgical procedures to which such requirements apply and information about the availability of the referral services described in this section. The Secretary shall make the applicable lists and information about referral services available at district and branch offices of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.".

(b) WAIVER OF DEDUCTIBLE AND COPAYMENTS.—

(1) DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended by striking out "and" before "(4)", and by inserting before the period at the end of the first sentence the following: ", and (5) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion)".

(2) COPAYMENTS.—(A) Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended by striking out "and" before "(F)", and by adding at the end thereof the following: "and (G) with respect to items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services;".

(B) Section 1833(a)(2)(A) of such Act (42 U.S.C. 1395l(a)(2)(A)) is amended by inserting ", items and services furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion)," after "(other than durable medical equipment)".

(C) Section 1833(a)(2)(D) of such Act (42 U.S.C. 1395l(a)(2)(D)) is amended by striking out "or to a provider having an agreement under section 1866" and inserting in lieu thereof "to a provider having an agreement under section 1866, or for tests furnished in connection with obtaining a second opinion required under section 1890 (or a third opinion, if such second opinion was in disagreement with the first opinion)".

(c) CONFORMING AMENDMENTS.—

(1) EXCLUSIONS FROM COVERAGE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395g(a)), as amended by section 147(a) of this Act, is amended—

(A) by striking out "or" at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; or"; and

(C) by adding at the end thereof the following new paragraph:

"(16) furnished in connection with a surgical procedure if a second opinion is required under section 1890 but is not obtained.".

(2) PROVIDER AGREEMENTS.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking out "and" at the end of subparagraph (G);

(B) by striking out the period at the end of subparagraph (H) and inserting in lieu thereof ", and"; and

(C) by inserting after subparagraph (H) the following new subparagraph:

"(I) to notify beneficiaries under this title for whom surgery is to be performed of the need to obtain a second opinion if such surgery is a procedure listed pursuant to section 1890.".

(3) FUNCTIONS OF PEER REVIEW ORGANIZATIONS.—Section 1154(a) of such Act (42 U.S.C. 1395c–3(a)) is amended by adding at the end thereof the following new paragraph:

"(12) The organization shall perform the referral functions for second opinions described in section 1890(c).".

(d) EFFECTIVE DATES.—(1) The amendments made by subsection (a) shall apply to items and services furnished on or after the first day of the first month which begins more than 6 months after the date of the enactment of this Act.

(2) The Secretary of Health and Human Services shall promulgate final regulations necessary to implement the amendments made by this section within 6 months after the date of the enactment of this Act.

(e) INTERIM LIST.—(1) If the Secretary of Health and Human Services has not established a list or lists of surgical procedures requiring second opinions, as required under section 1890 of the Social Security Act, within 6 months after the date of the enactment of this Act, then the following list shall be in effect for purposes of such section:

Coronary artery bypass.

Cardiac pacemaker implantation.

Cataract surgery.

Gall bladder surgery.

Prostate surgery.

Knee surgery.

Hysterectomy.

Back surgery.

Hernia repair.

Hemorrhoidectomy.

(2) The list in paragraph (1) shall remain in effect until such time as the Secretary establishes a new list for the applicable State or area pursuant to section 1890.

(f) STUDY.—The Secretary of Health and Human Services shall conduct a study of the results of the amendments made by this section. Such study shall include any changes in utilization of surgical procedures, changes in nonconfirmation rates of second opinions, and outcomes in cases where surgery is not done after a second opinion failed to confirm the necessity of the surgical procedure. The Secretary shall report the results of the study to the Congress within 30 months after the date of the enactment of this Act.

SEC. 157. CHANGING MEDICARE APPEAL RIGHTS.

(a) PERMITTING PROVIDER REPRESENTATION OF BENEFICIARIES.—Section 1869(b)(1) of the Social Security

Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following new sentence: "Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item.".

(b) REVIEW OF PART B DETERMINATIONS.—(1) Section 1869 of such Act (42 U.S.C. 1395ff) is further amended—

(A) by inserting "or part B" in subsection (a) after "amount of benefits under part A",

(B) by inserting "or part B" in subsection (b)(1)(C) after "part A", and

(C) by amending paragraph (2) of subsection (b) to read as follows:

"(2) Notwithstanding paragraph (1)(C), in the case of a claim arising—

"(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than $1,000; or

"(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than $500 and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.".

(2) Section 1842(b)(3)(C) of such Act (42 U.S.C. 1395u(b)(3)(C)) is amended by striking out "$100 or more" and inserting in lieu thereof "at least $100, but not more than $500".

(3) Section 1879(d) of such Act (42 U.S.C. 1395pp(d)) is amended by striking out "section 1869(b)" and all that follows through "part B)" and inserting in lieu thereof "sections 1869(b) and 1842(b)(3)(C) (as may be applicable)".

(c) EFFECTIVE DATES.—(1) The amendment made by subsection (a) takes effect on the date of the enactment of this Act.

(2) The amendments made by subsection (b) shall apply to claims submitted on or after October 1, 1985.

SEC. 158. EXTENSION OF ON LOK WAIVER.

(a) CONTINUED APPROVAL.—

(1) MEDICARE WAIVERS.—Notwithstanding any limitations contained in section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, the Secretary of Health and Human Services shall continue approval of the risk-sharing application (described in section 603(c)(1) of Public Law 98-21) for waivers of certain requirements of title XVIII of the Social Security Act after the end of the period described in that section.

(2) MEDICAID WAIVERS.—Notwithstanding any limitations contained in section 1115 of the Social Security Act, the Secretary shall approve any application of the Department of Health Services, State of California, for a waiver of requirements of title XIX of such Act in order to continue carrying out the demonstration project referred to in section 603(c)(2) of Public Law 98-21 after the end of the period described in that section.

(b) TERMS, CONDITIONS, AND PERIOD OF APPROVAL.—The Secretary's approval of an application (or renewal of an application) under this section—

(1) shall be on the same terms and conditions as applied with respect to the corresponding application under section 603(c) of Public Law 98-21 as of July 1,

1985, except that requirements relating to collection and evaluation of information for demonstration purposes (and not for operational purposes) shall not apply; and

(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with the terms and conditions described in paragraph (1).

PART E—CHANGES RELATING TO THE MEDICAID PROGRAM

SEC. 161. SERVICES FOR PREGNANT WOMEN.

(a) EXPANDED COVERAGE.—Section 1905(n)(1) of the Social Security Act (42 U.S.C. 1396d(n)(1)) is amended—

(1) by striking out "; or" at the end of subparagraph (A) and inserting in lieu thereof a comma,

(2) by striking out "; and" at the end of subparagraph (B) and inserting in lieu thereof ", or", and

(3) by adding after subparagraph (B) the following new subparagraph:

"(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and".

(b) OPTIONAL EXPANSION OF PREGNANCY-RELATED SERVICES.—Section 1902(a)(10) of such Act (42 U.S.C.

1396a(a)(10)) is amended, in the matter after subparagraph (D) thereof—

(1) by striking out "and" before "(IV)" and inserting in lieu thereof a comma, and

(2) by inserting before the semicolon the following: ", and (V) the making available to all pregnant women covered under the plan of services relating to pregnancy (including pre-natal, delivery, and post-partum services) or to any other condition which may complicate pregnancy shall not, by reason of subparagraph (B), require the making available of these services, or the making available of such services of the same amount, duration, and scope, to any other individuals".

(c) POST-PARTUM ELIGIBILITY FOR PREGNANT WOMEN.—Section 1902(e) of such Act (42 U.S.C. 1396b(e)) is amended by adding at the end the following new paragraph:

"(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall be deemed to remain pregnant, for purposes of the provision of all pregnancy-related and post-partum medical assistance under the plan, until the end of the 60-day period beginning on the last day of her pregnancy.".

(d) EFFECTIVE DATES.—

(1) EXPANDED COVERAGE.—(A) The amendments made by subsection (a) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after October 1, 1985, without regard to whether or not final regulations to carry out the amendments have been promulgated by that date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(2) OPTIONAL SERVICES.—The amendments made by subsection (b) shall take effect on October 1, 1985.

(3) CONTINUED COVERAGE.—The amendment made by subsection (c) shall apply to medical assist-

ance furnished to a woman on or after October 1, 1985.

SEC. 162. MODIFICATIONS OF HOME AND COMMUNITY-BASED WAIVER UNDER SECTION 1915(c).

(a) EXPLICIT INCLUSION OF CERTAIN VOCATIONAL, PREVOCATIONAL, AND EDUCATIONAL SERVICES.—Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) is amended by adding at the end the following new paragraph:

"(5) For purposes of paragraph (4)(B), the term 'habilitation services', with respect to individuals who receive such services after discharge from a skilled nursing facility or intermediate care facility—

"(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings, and

"(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services, but

"(C) does not include—

"(i) special education and related services (as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a local educational agency, and

"(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).".

(b) PERMITTING HOSPITAL LEVEL OF CARE FOR CERTAIN PARTICIPANTS.—(1) Paragraph (1) of such section is amended by inserting "or but for the provision of such services the individuals would continue to receive inpatient hospital services because they are dependent on ventilator support the cost of which is reimbursed under the State plan" before the period at the end.

(2) Paragraph (2)(C) of such section is amended—

(A) by inserting "hospital or" after "provided in a", and

(B) by inserting "inpatient hospital services or" after "the provision of".

(c) PROHIBITING IMPOSITION OF CERTAIN REGULATORY LIMITS.—Such section, as amended by subsection (a), is further amended—

(1) in paragraph (2)(D), by inserting "100 percent of" after "does not exceed", and

(2) by adding at the end the following new paragraph:

"(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph

(2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.''.

(d) COMPUTATION OF EXPENDITURES FOR CERTAIN DISABLED PATIENTS.—Such section, as amended by subsection (c), is further amended by adding at the end the following new paragraph:

''(7) In making estimates under paragraph (2)(D) in the case of a waiver which applies only to physically disabled individuals who are inpatients in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under the State plan separately from the expenditure for other individuals who are inpatients of those facilities.''.

(e) PERMITTING FLEXIBILITY IN ESTABLISHING MAINTENANCE INCOME STANDARDS.—Paragraph (3) of such section is amended by adding at the end the following new sentence: ''A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving

services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.".

(f) EFFECTIVE DATES.—

(1) HABILITATION SERVICES AND HOSPITALIZED PATIENTS.—The amendments made by subsections (a) and (b) are effective for services furnished on or after October 1, 1985.

(2) PROHIBITION OF REGULATORY LIMITS AND TREATMENT OF CERTAIN PHYSICALLY DISABLED INDIVIDUALS.—The amendments made by subsections (c) and (d) shall apply to applications for waivers filed before, on, or after, the date of the enactment of this Act and for services furnished on or after August 13, 1981.

(3) INCOME STANDARDS.—The amendment made by subsection (e) shall apply to waivers approved on or after the date of the enactment of this Act.

(g) TASK FORCE ON ALTERNATIVE CARE FOR TECHNOLOGY-DEPENDENT, CHRONICALLY ILL CHILDREN.—(1) The Secretary of Health and Human Services, within six months after the date of the enactment of this Act, shall establish a task force concerning alternatives to institutional

care for technology-dependent children (as defined in paragraph (5)).

(2) The task force shall include representatives of Federal and State agencies with responsibilities relating to child health, health insurers, large employers (including those that self-insure for health care costs), providers of health care to technology-dependent children, and parents of technology-dependent children.

(3) The task force shall—

(A) identify barriers that prevent the provision of appropriate care in a home or community-setting to meet the special needs of technology-dependent children, and

(B) recommend changes in the provision and financing of health care in private and public health care programs (including appropriate joint public-private initiatives) so as to provide home and community-based alternatives to the institutionalization of technology-dependent children.

(4) The task force shall make a final report to the Secretary and to the Congress on its activities not later than two years after the date of the enactment of this Act.

(5) In this subsection, the term "technology-dependent child" means a child who has a chronic illness which makes

the child dependent upon the continuing use of medical care technology (such as a ventilator).

SEC. 163. OPTIONAL HOSPICE BENEFITS.

(a) COVERAGE OF HOSPICE CARE AS AN OPTIONAL MEDICAID BENEFIT.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) by striking out "and" at the end of paragraph (17),

(B) by redesignating paragraph (18) as paragraph (19), and

(C) by inserting after paragraph (17) the following new paragraph:

"(18) hospice care (as defined in subsection (o)); and"; and

(2) by adding at the end the following new subsection:

"(o)(1) The term 'hospice care' means the care described in section 1861(dd)(1) furnished by a public, or private non-profit, hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to receive hospice care instead of certain other benefits (described in section 1812(d)(2)) under the plan.

"(2) An individual's voluntary election under this subsection—

"(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2),

"(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish, and

"(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.".

(b) ELIGIBILITY.—

(1) LIMITATION TO TERMINALLY ILL INDIVIDUALS.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)), as amended by section 161(b) of this Act, is further amended, in the matter following subparagraph (D), by striking out "and" before "(V)" and by inserting before the semicolon the following: ", and (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance

may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals".

(2) HIGHER INCOME STANDARD PERMITTED.—Section 1902(a)(10)(A)(ii) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) by striking out "or" at the end of subclause (V),

(B) by striking out the semicolon at the end of subclause (VI) and inserting in lieu thereof ", or", and

(C) by adding at the end the following new subclause:

"(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o);".

(c) PAYMENT FOR HOSPICE CARE.—

(1) USE OF MEDICARE RATES.—Section 1902(a)(13) of such Act (42 U.S.C. 1396a(a)(13)) is amended—

(A) by striking out "and" at the end of subparagraph (B),

(B) by redesignating subparagraph (C) as subparagraph (D), and

(C) by inserting after subparagraph (B) the following new subparagraph:

"(C) for payment for hospice care in the same amounts, and using the same methodology, as used under part A of title XVIII; and".

(2) LIMITATION ON COPAYMENTS.—Subsections (a)(2) and (b)(2) of section 1916 of the Social Security Act (42 U.S.C. 1396o) are each amended—

(A) by striking out "or" at the end of subparagraph (C),

(B) by striking out "; and" at the end of subparagraph (D) and inserting in lieu thereof ", or", and

(C) by adding at the end the following new subparagraph:

"(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and".

(d) CONFORMING AMENDMENTS.—

(1) Section 1902(j) of such Act (42 U.S.C. 1396a(j)) is amended by striking out "(18)" and inserting in lieu thereof "(19)".

(2) Section 1902(a)(10)(C)(iv) of such Act (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking out "through (17)" and inserting in lieu thereof "through (18)".

(e) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance provided for hospice care furnished on or after October 1, 1985.

SEC. 164. MEDICAID PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS OF HOSPITALS.

(a) MEDICAID PAYMENT METHODOLOGY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 163(c)(1) of this Act, is further amended—

(1) in paragraph (13) of subsection (a)—

(A) by striking out "and" at the end of subparagraph (C),

(B) by redesignating subparagraph (D) as subparagraph (E), and

(C) by inserting after subparagraph (C) the following new subparagraph:

"(D) for payment to hospitals for direct medical education costs in amounts determined in accordance with subsection (h); and"; and

(2) by inserting before subsection (i) the following new subsection:

"(h) PAYMENTS FOR DIRECT MEDICAL EDUCATION COSTS.—

"(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Instead of any amounts that are otherwise payable under a State plan with respect to the costs of hospitals for direct medical education costs, the State shall provide for payments to hospitals for such costs in accordance with paragraph (3) of this subsection.

"(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each residency year beginning on or after July 1, 1985, as follows:

"(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD.—The Secretary shall determine, based on data from the most recent available audited cost report of the hospital, the average amount recognized as reasonable under title XVIII for

direct medical education costs of the hospital for each full-time-equivalent resident.

"(B) UPDATING UP THROUGH JUNE 1985.—The Secretary shall update each average amount determined under subparagraph (A) through June 1985 by the percentage increase in the consumer price index from the midpoint of the cost reporting periods used under subparagraph (A) to the end of December 1984.

"(C) AMOUNT FOR RESIDENCY YEAR BEGINNING JULY 1, 1985.—For the residency year beginning July 1, 1985, the approved FTE resident amount for each hospital is equal to the amount determined under paragraph (B) for that hospital updated, to the end of December 1985, by projecting the estimated percentage increase in the consumer price index during the 12-month period ending with December 1985.

"(D) AMOUNT FOR SUBSEQUENT RESIDENCY YEARS.—

"(i) GENERAL RULE.—Except as provided in clause (ii), for each residency year beginning after July 1, 1985, the approved FTE resident amount for each hospital is equal to the amount determined under this

paragraph for the previous residency year updated by projecting the estimated percentage change in the consumer price index during the 12-month period ending with December of that residency year, with appropriate adjustments to reflect previous under- or over-estimations under this paragraph in the projected percentage change in the consumer price index.

"(ii) LIMITATION ON APPROVED FTE RESIDENT AMOUNTS.—The approved FTE resident amount for a hospital for a residency year may not exceed—

"(I) for the residency year beginning on July 1, 1986, 175 percent,

"(II) for the residency year beginning on July 1, 1987, 150 percent, and

"(III) for residency years beginning on or after July 1, 1988, 125 percent,

of the median amounts determined under clause (i) for all the hospitals in the United States for that residency year.

"(E) TREATMENT OF CERTAIN HOSPITALS.—In the case of a hospital that did not

have an approved medical residency training program and was not participating in the program under title XVIII for a cost reporting period ending before 1985, the Secretary shall provide, for the first such period for which it has such a residency training program and is participating under this title, for such approved FTE resident amount as the Secretary determines to be appropriate, based on comparable approved FTE resident amounts for similar programs of similar hospitals located in similar areas.

"(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

"(A) IN GENERAL.—The payment amount, for a hospital cost reporting period beginning on or after October 1, 1985, is equal to the product of—

"(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

"(ii) the hospital's medicaid patient load (as defined in subparagraph (C)) for that period.

"(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term 'aggregate ap-

proved amount' means, for a hospital cost reporting period, the sum of the products, for each residency year occurring during the cost reporting period, of—

"(i) the fraction of that residency year that occurs during the period,

"(ii) the hospital's approved FTE resident amount (determined under paragraph (2)) for that residency year, and

"(iii) the number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital's approved medical residency training programs in that year.

"(C) MEDICAID PATIENT LOAD.—As used in subparagraph (A), the term 'medicaid patient load' means, with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the reporting period which are attributable to patients with respect to whom payment may be made under the State plan approved under this part.

"(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

"(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

"(B) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that time so spent by a resident under an approved medical residency training program in an outpatient clinic, facility of a health maintenance organization, or other ambulatory setting shall be counted towards the determination of full-time equivalency.

"(C) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a residency year with a hospital or simultaneously with more than one hospital.

"(D) WEIGHTING FACTORS FOR PRIMARY CARE AND OTHER SPECIALTIES.—Subject to subparagraphs (E) and (F), such rules shall provide, in calculating the number of full-time-equivalent residents in approved residency program for residency years beginning on or after July 1,

1987, for the application of a weighting factor for residents determined in accordance with the following table:

"For the residency year beginning in—	The weighting factor for each—		
	(i) primary care resident is—	(ii) other resident—	
		(I) during the initial residency period is—	(II) during any other period is—
1987	1.10	.90	.75
1988	1.20	.80	.50
1989 or later	1.30	.70	.50

"(E) ALTERNATIVE COMPUTATIONS OF FULL-TIME EQUIVALENTS.—For residency years beginning on or after July 1, 1989, the Secretary may change the weighting factors described in the table in subparagraph (D) or may establish alternative methods for calculating the number of full-time equivalent residents, based on recommendations of the Physician Payment Review Commission (established under section 1845).

"(F) SPECIAL RULES FOR FOREIGN MEDICAL GRADUATES.—

"(i) REQUIRED TO PASS FMGEMS EXAMINATION.—Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the

individual shall not be counted as a resident for a residency year beginning on or after July 1, 1986, unless the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)) before the beginning of the residency year.

"(ii) TRANSITION FOR CURRENT FMGS.—For the residency year beginning on July 1, 1986, in the case of a foreign medical graduate who—

"(I) has served as a resident before that year and is serving as a resident during that year, but

"(II) has not passed the FMGEMS examination before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

"(iii) TREATMENT OF CERTAIN ECFMG-CERTIFIED INDIVIDUALS.—For purposes of this subparagraph, the Secretary may provide for an individual to be treated as having passed the FMGEMS examination if the individual is unable to take that examination

because the individual has previously received certification from the Educational Commission for Foreign Medical Graduates.

"(5) DEFINITIONS.—As used in this subsection:

"(A) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved medical residency training program' means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

"(B) CONSUMER PRICE INDEX.—As used in this paragraph, the term 'consumer price index' refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

"(C) DIRECT MEDICAL EDUCATION COSTS.—The term 'direct medical education costs' means direct costs of approved educational activities for approved medical residency training programs.

"(D) FOREIGN MEDICAL GRADUATE.—The term 'foreign medical graduate' means an individual who is a graduate of a medical school not ac-

credited by a body or bodies approved for this purpose by the Secretary of Education (regardless of whether the school of medicine is in the United States).

"(E) FMGEMS EXAMINATION.—The term 'FMGEMS examination' means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences recognized by the Secretary for this purpose.

"(F) INITIAL RESIDENCY PERIOD.—The term 'initial residency period' means, in the case of a resident, the minimum number of years of formal training necessary to satisfy the requirements (as specified in the 1985–1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education) for initial board eligibility in the particular specialty for which the resident is training; except that—

"(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of residency of more than five years for any individual, and

"(ii) a period, of not more than two years, during which an individual is a resi-

dent in the field of geriatric medicine or the field of public health and preventive health shall not be counted towards the initial residency period.

"(G) PRIMARY CARE RESIDENT.—The term 'primary care resident' means an individual during the individual's first three years of postgraduate medical training in the field of internal medicine, pediatrics, or family medicine, but does not include such an individual who—

"(i) has been accepted for postgraduate medical training in a field other than internal medicine, pediatrics, family medicine, geriatric medicine, or public health and preventive medicine, and

"(ii) is receiving such training as part of the initial training for that field.

Such term also includes an individual during up to two years of postgraduate medical training in the field of geriatric medicine or the field of public health and preventive medicine.

"(H) RESIDENCY YEAR.—The term 'residency year' means a 12-month period beginning on July 1.

"(I) RESIDENT.—The term 'resident' includes an intern or other participant in an approved medical residency training program.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after July 1, 1986, under State plans approved under title XIX of the Social Security Act; except that such amendments shall not apply to such payments for costs incurred (or services rendered) before that date.

(d) REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS.—The Secretary of Health and Human Services shall report to Congress, not later than December 31, 1986, on whether section 1902(h) of the Social Security Act should be revised to provide for greater uniformity in the approved FTE resident amounts established under paragraph (2) of that section, and, if so, how such revisions should be implemented.

SEC. 165. TREATMENT OF POTENTIAL PAYMENTS FROM MEDICAID QUALIFYING TRUSTS.

(a) AMOUNTS TREATED AS BEING AVAILABLE FROM GRANTOR TRUSTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

"(k)(1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed

available to a grantor, for purposes of subsection (a)(17), is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term 'grantor' means the individual referred to in paragraph (2).

"(2) For purposes of this subsection, a 'medicaid qualifying trust' is a trust, or similar legal device, established by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

"(3) This subsection shall apply without regard to—

"(A) whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medical assistance under this title, or

"(B) whether or not the discretion described in paragraph (2) is actually exercised.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to medical assistance furnished on or after the first day of the second month beginning after the date of the enactment of this Act.

SEC. 166. WRITTEN STANDARDS FOR PROVISION OF ORGAN TRANSPLANTS.

(a) DENIAL OF FEDERAL PAYMENTS FOR ORGAN TRANSPLANTS UNLESS PROVIDED UNDER WRITTEN STANDARDS.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended by inserting before paragraph (2) the following new paragraph:

"(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

"(A) similarly situated individuals are treated alike, and

"(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance furnished on or after July 1, 1986.

SEC. 167. DEEMED RESIDENCE FOR OUT-OF-STATE ADOPTIVE AND FOSTER CARE PLACEMENTS.

(a) GENERAL RULE.—Section 1902(b) of the Social Security Act (42 U.S.C. 1396a(b)) is amended by adding at the end the following:

"For purposes of this title, any individual receiving aid or assistance under any plan of a State approved under part E of title IV shall be deemed to be receiving such aid or assistance from the State in which the individual actually resides.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of the enactment of this Act.

SEC. 168. EXTENSION OF MMIS DEADLINE.

(a) NEW DEADLINE.—Section 1903(r)(1)(B) of the Social Security Act (42 U.S.C. 1396b(r)(1)(B)) is amended by striking out "the earlier of" and all that follows through the end of subparagraph (B) and inserting in lieu thereof "September 30, 1985.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payment under section 1903(a) of the Social Security Act for calendar quarters beginning on or after October 1, 1982.

SEC. 169. EXTENSION OF CERTAIN WAIVER PROJECT.

(a) CONTINUED APPROVAL.—Notwithstanding any limitations contained in section 1115 of the Social Security Act but subject to subsection (b) of this section, the Secretary of Health and Human Services, upon application, shall continue approval of demonstration project number 11–P–97473/6–

06 ("Modifications under the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged"), previously approved under that section, until December 31, 1988.

(b) TERMS AND CONDITIONS.—The Secretary's continued approval of the project under subsection (a)—

(1) shall be on the same terms and conditions as applied to the project as of the date of the enactment of this Act, and

(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with such terms and conditions.

SEC. 170. REPORT ON ADJUSTMENT IN MEDICAID PAYMENTS FOR HOSPITALS SERVING DISPROPORTIONATE NUMBERS OF LOW INCOME PATIENTS.

The Secretary of Health and Human shall transmit to Congress, not later than July 1, 1986, a report that—

(1) describes the methodology used by States under section 1902(a)(13)(A) of the Social Security Act, in their making payments to hospitals, in taking into account the situation of hospitals that serve a disproportionate number of low income patients with special needs,

(2) identifies each of those hospitals that have had the amount of their payments under that title adjusted under that section, and

(3) for each of those hospitals, describes the proportion of total inpatient-days attributable to low income patients and the proportion of total inpatient-days attributable to patients entitled to medical assistance under that title.

SEC. 171. REFERENCE TO PROVISIONS OF LAW PROVIDING COVERAGE UNDER, OR DIRECTLY AFFECTING, THE MEDICAID PROGRAM.

Title XIX of the Social Security Act is amended by adding at the end the following new section:

"REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

"SEC. 1919. (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law that make additional individuals eligible for medical assistance under this title, see the following:

"(1) AFDC.—(A) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

"(B) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

"(C) Section 414(g) of this Act (relating to certain individuals participating in work supplementation programs).

"(2) SSI.—Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

"(3) REFUGEE ASSISTANCE.—Section 412(e)(5) of the Immigration and Nationality Act (relating to medical assistance for certain refugees).

"(4) MISCELLANEOUS.—(A) Section 230 of Public Law 93–66 (relating to deeming eligible for medical assistance certain essential persons).

"(B) Section 231 of Public Law 93–66 (relating to deeming eligible for medical assistance certain persons in medical institutions).

"(C) Section 232 of Public Law 93–66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons).

"(D) Section 13(c) of Public Law 93–233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments).

"(E) Section 503 of Public Law 94–566 (popularly known as the 'Pickle Amendment', relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits).

"(b) ADDITIONAL STATE PLAN REQUIREMENTS.—For other provisions of law that establish additional requirements for State plans to be approved under this title, see the following:

"(1) Section 1618 of this Act (relating to requirement for operation of certain State supplementation programs).

"(2) Section 212(a) of Public Law 93–66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).".

PART F—PRIVATE HEALTH INSURANCE CONTINUATION

SEC. 181. TEMPORARY EXTENSION OF COVERAGE AT GROUP RATES FOR FAMILY MEMBERS OF DECEASED, DIVORCED, OR MEDICARE-ELIGIBLE WORKERS.

(a) IN GENERAL.—Subsection (i) of section 162 of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans) is amended—

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1) the following new paragraph:

"(2) CONTINUATION COVERAGE.—

"(A) REQUIRING OPTION OF CONTINUATION COVERAGE WHEN QUALIFIED BENEFICIARY WOULD LOSE COVERAGE.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section unless each qualified beneficiary who would lose coverage under the plan because of a qualifying event is given, in accordance with this paragraph, the option of electing continuation coverage under the plan.

"(B) ELECTION.—

"(i) ELECTION PERIOD.—The option of electing continuation coverage must be offered during a period that—

"(I) begins not later than the termination date (as defined in subparagraph (C)(ii)),

"(II) is of at least 60 days duration, and

"(III) ends not earlier than 60 days after the date the qualified beneficiary is notified under subparagraph (F)(iv) or the termination date, whichever date is later.

"(ii) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Unless otherwise specified in the election, any such election by a qualified beneficiary described in subparagraph (G)(ii)(I) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary whose coverage would, but for continuation coverage provided in accordance with this paragraph, be affected by the qualifying event.

"(C) QUALIFYING EVENT AND TERMINATION DATE.—For purposes of this paragraph—

"(i) A 'qualifying event' under a group health plan, with respect to a covered employee, is any of the following events if coverage of a qualified beneficiary under the plan would, but for continuation coverage provided in compliance with this paragraph, be terminated by the occurrence of the event:

"(I) The death of the covered employee.

"(II) The divorce or separation of the covered employee from the employee's spouse.

"(III) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(ii) The term 'termination date' means, with respect to a qualifying event, the date on which coverage of a qualified beneficiary under a group health plan would be terminated under the plan but for continuation coverage provided in compliance with this paragraph.

"(D) TERMS OF CONTINUATION COVERAGE.—Any continuation coverage elected by or on behalf of a qualified beneficiary shall meet the following requirements:

"(i) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(ii) CONTINUED BENEFITS.—The coverage shall consist of coverage which is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(iii) PERIOD OF CONTINUED COVERAGE.—The coverage shall be for a period commencing upon the termination date and ending not earlier than the earliest of the following:

"(I) MAXIMUM OF FIVE YEARS.—Five years after the termination date.

"(II) END OF PLAN.—The date on which the employer ceases to provide any group health plan to employees.

"(III) FAILURE TO PAY PREMIUMS.—The date on which there is a failure in making timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(IV) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes or could become, after the date of the election, a covered employee under any other group health plan or becomes entitled to benefits under title XVIII of the Social Security Act.

"(V) REMARRIAGE OF SPOUSE.—In the case of a qualified beneficiary de-

scribed in subparagraph (G)(ii)(I), the date on which the beneficiary remarries and becomes (or could become) covered under a group health plan as the spouse of a covered employee.

"(VI) CHILD TURNING MAJORITY.—In the case of an individual who is a qualified beneficiary by reason of having been a covered dependent child of a covered employee, the date on which the individual ceases to be a covered dependent child of the covered employee.

"(iv) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continued coverage expires under clause (iii)(I), the plan must provide to the beneficiary, during the 180-day period ending on the date of expiration of the period of continued coverage, the option of enrollment under a conversion health plan otherwise generally available to beneficiaries under the plan.

"(E) PREMIUMS FOR CONTINUATION COVERAGE.—

"(i) AMOUNT.—The total premium charged by a group health plan with respect to any qualified beneficiary for continuation coverage under the plan shall not exceed the sum of employer premiums and employee premiums generally charged with respect to coverage under the plan of similarly situated beneficiaries with respect to whom a qualifying event has not occurred. The total of all premiums charged by the plan in any plan year may be based upon reasonably anticipated community costs for such plan year of the entire pool of covered employees and other beneficiaries under the plan, including qualified beneficiaries receiving continuation coverage under the plan under this paragraph.

"(ii) PAYMENTS.—The plan may provide for payment of the total premium by the qualified beneficiary receiving such coverage, or for payment of all or part of such premium by the employer or other party and payment of the remainder of such premium by such beneficiary. The plan shall provide for payment of any premium by a qualified bene-

ficiary in monthly installments if so elected by the beneficiary. If an election is made during an election period but after the termination date, the plan shall permit payment of any premium for continuation coverage during the preceding period to be made within 45 days of the date of the election.

"(iii) PREMIUM DEFINED.—As used in this subparagraph, the term 'premium' means any amount payable with respect to the provision of coverage under a group health plan.

"(F) NOTICE REQUIREMENTS.—In accordance with regulations of the Secretary—

"(i) the group health plan must provide, at the time of commencement of coverage under the plan, for written notice to each covered employee and spouse of the employee (if any) of the rights provided under this paragraph;

"(ii) the employer of a employee under the plan must notify the group health plan administrator if the employee dies;

"(iii) each covered employee is responsible for notifying the group health plan administrator of the occurrence of any qualify-

ing event (other than that described in subparagraph (C)(i)(I)) respecting that employee; and

"(iv) the group health plan administrator must notify each qualified beneficiary, within a period of 14 days after the date the administrator is notified concerning the occurrence of a qualifying event affecting that beneficiary, of—

"(I) the termination date with respect to the beneficiary, and

"(II) the beneficiary's right to elect continuation coverage under this paragraph and the election period established under subparagraph (B)(i) during which the beneficiary can exercise that right.

"(G) DEFINITIONS.—For purposes of this paragraph—

"(i) COVERED EMPLOYEE.—The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(ii) QUALIFIED BENEFICIARY.—The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the date before the date of a qualifying event for that employee—

"(I) is a beneficiary under the plan as the spouse of the employee and has been married to the employee for at least the immediately preceding 30-day period, or

"(II) is a beneficiary under the plan as a covered dependent child of the employee.

"(iii) COVERED DEPENDENT CHILD.—The term 'covered dependent child' means, with respect to a covered employee, an individual who meets the generally applicable requirements of the plan for treatment as a dependent child covered under the plan by reason of the coverage of the employee under the plan.

"(iv) GROUP HEALTH PLAN ADMINISTRATOR.—The term 'group health plan administrator' means, in connection with a

group health plan, any person who provides for administrative functions relating to enrollment of individuals under the plan. For purposes of this subparagraph, the term 'person' includes one or more individuals, governments or agencies of the United States or any State or political subdivision thereof, labor unions, partnerships, associations, corporations, legal representatives, mutual companies, joint ventures, joint stock companies, societies, trusts, unincorporated organizations, trustees, trustees in bankruptcy, receivers, and fiduciaries.".

(b) CONFORMING AMENDMENT.—Paragraph (1) of section 162(i) of such Code is amended by striking out "GENERAL RULE" and inserting in lieu thereof "COVERAGE RELATING TO END STAGE RENAL DISEASE".

(c) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after January 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and

one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the earlier of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(d) NOTIFICATION TO COVERED EMPLOYEES.—At the time that the amendments made by this section apply to a group health plan described in section 162(i) of the Internal Revenue Code of 1954, the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under paragraph (2) of that section. The notice furnished under this subsection is in lieu of notice that may otherwise be required under paragraph (2)(F)(i) of that section.

PART G—TASK FORCE ON LONG-TERM HEALTH CARE POLICIES

SEC. 191. GUIDELINES FOR LONG-TERM HEALTH CARE POLICIES.

(a) ESTABLISHMENT OF TASK FORCE.—(1) The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a Task Force on Long-Term Health Care Policies (hereinafter in this section referred to as the "Task Force"). The Task Force shall be established not later than 60 days after the date of the enactment of this Act and in consultation with the National Association of Insurance Commissioners.

(b) COMPOSITION OF TASK FORCE.—The Task Force shall be composed of 18 members, which shall include—

(1) two members representing the National Association of Insurance Commissioners,

(2) three members representing Federal and State agencies with responsibilities relating to health or the elderly,

(3) three members representing private insurers,

(4) three members from organizations representing consumers or the elderly, and

(5) three members from organizations representing providers of long-term health care services.

The Secretary shall designate a member of the Task Force as chair.

(c) DEVELOPMENT OF GUIDELINES.—The Task Force shall develop guidelines for long-term health care policies, including guidelines designed—

(1) to limit marketing and agent abuse for those policies,

(2) to assure the dissemination of such information to consumers as is necessary to permit informed choice in purchasing the policies and to reduce the purchase of unnecessary or duplicative coverage,

(3) to assure that benefits provided under the policies are reasonable in relationship to premiums charged, and

(4) to promote the development and availability of long-term health care policies which meet these guidelines.

(d) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Task Force shall report to the Secretary and Congress respecting—

(1) the guidelines developed under subsection (c), including an explanation of the reasons for their selection, and

(2) such recommendations for additional activities respecting long-term health care policies as the Task Force finds appropriate.

The Secretary, in cooperation with the National Association of Insurance Commissioners, shall provide for the dissemination of the report to each of the States.

(e) ANNUAL REPORT OF SECRETARY.—The Secretary shall annually report to Congress on—

(1) actions taken by the States to implement the guidelines developed under this section,

(2) recommendations for the development of additional guidelines (or modification of proposed guidelines), and

(3) recommendations for legislative and administrative action needed to respond to issues raised by the Task Force or to improve consumer protection with respect to long-term health care policies.

(f) LONG-TERM HEALTH CARE POLICY DEFINED.—In this section, the term "long-term health care policy" means an insurance policy, or similar health benefits plan, which is designed for or marketed as providing (or making payments for) health care services (such as nursing home care and home health care) or related services (which may include home and community-based services), or both, over an extended period of time.

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